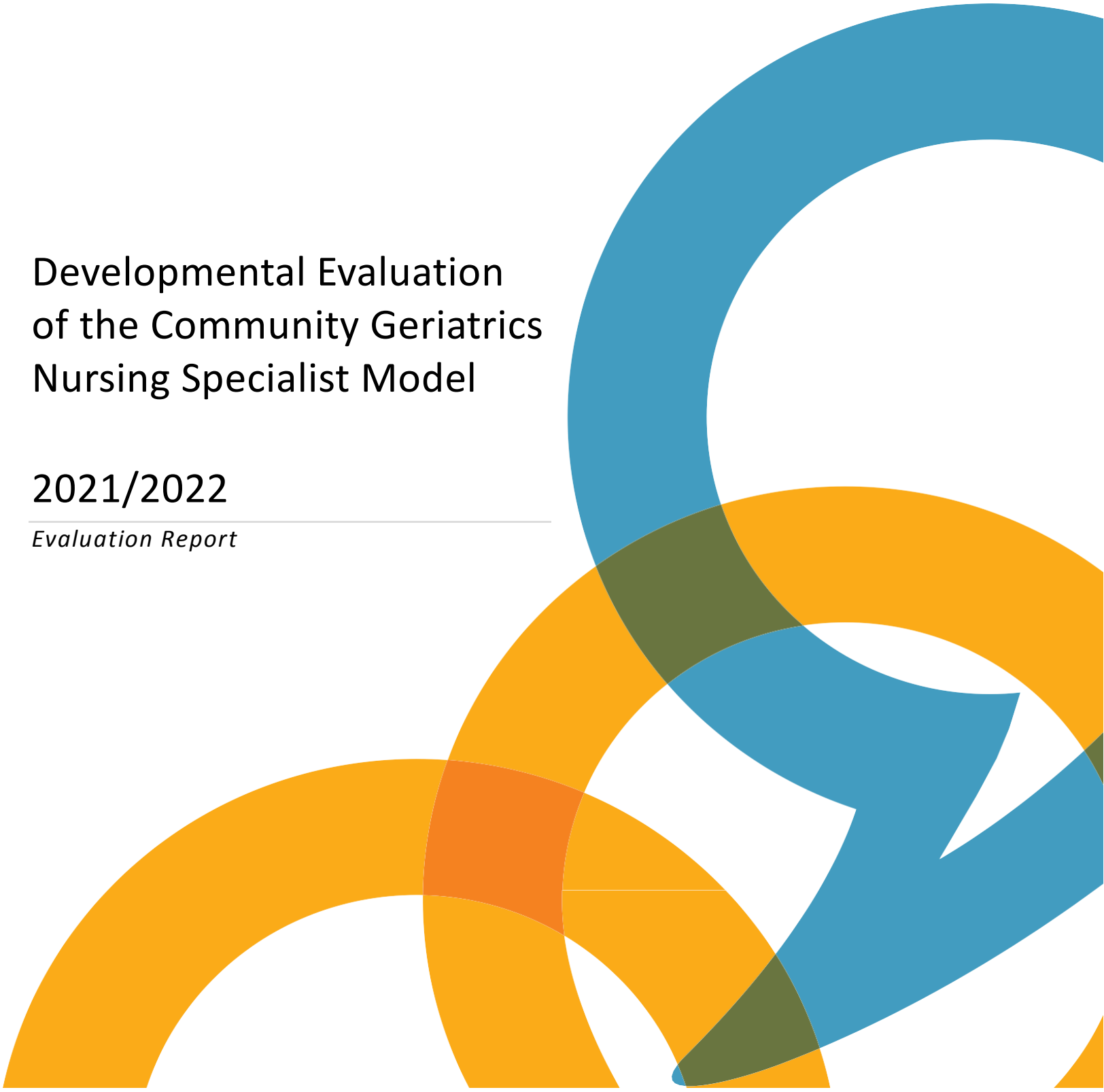
Developmental Evaluation of the Community Geriatrics Nursing Specialist Model

2021/2022

Evaluation Report



Developmental Evaluation of the Community Geriatrics Nursing Specialist Model

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EXECUTIVE SUMMARY

Older adults living with frailty or at-risk of frailty and their care partners has been identified as a priority population by the Durham OHT. The Community Geriatric Nursing Specialist (CGNS) project is among the Year One Projects. One of the goals of the project is to enhance rapid front-line nursing response to older adults living in the community who are at risk, or who have experienced a sudden or unexpected change in their health condition. Following the preliminary work, the project was operationalized in June 2021 and concluded in February 2022.

The CGNS model underwent a vigorous developmental evaluation (DE). DE is a type of evaluation that supports real-time, adaptive learning. It is suitable for initiatives with multiple stakeholders, high levels of innovation &/or complexity, fast paced decision-making, and areas of uncertainty[1]. Through developmental evaluation, insights were gathered to facilitate timely CGNS model refinement, test assumptions and to identify promising practices for permanent adoption. However, many of the recommendations made were not adopted and/or followed through.

Although the future of the project is unknown at this time, if a decision to continue with the CGNS service is made, the following recommendation should be implemented:

- Utilize data to help inform the need for a CSS-based nursing service for older adults experiencing a sudden or unexpected change in their condition
- Collaborate with Emergency Medical Services to identify the clientele that may best benefit from services like CGNS
- Communicate with other Durham OHT sub-groups/committees to identify synergies among existing and/or prospective older adult-focused projects and initiatives (e.g., Community Paramedicine, Virtual Urgent Care, Seniors Urgency Room, etc.) to explore collaboration
- Consult with key stakeholders such as Primary Care Providers (PCP) prior to (re)initiating
- Eliminate structural barriers such as:
  - hiring staff with diagnostic and prescribing privileges i.e., NP role
  - timely access to electronic information systems such as Connecting ON,
  - on-site clinical supervision
- Follow-up on recommendations made by the Project Team including opportunities for quick course-correction identified by the Developmental Evaluation such as, identification of the appropriate clientele (through EMS, ER utilization data, etc.) and expansion of referral sources (e.g., PCP and GEM referrals outside of Supportive Housing).

[1] Adapted from Patton, 2008

EVALUATION PLAN

BACKGROUND

Despite a strong foundation of expertise in specialized geriatrics services (SGS), Durham residents in need of SGS encounter a system plagued by delayed interventions and lengthy wait lists. This situation, a problem currently exacerbated by COVID-19, prevents teams from actively preventing avoidable events and supporting those living with complex and chronic health conditions and/or frailty or at risk of frailty. Community Support Services (CSS) provide a broad reach of services (Adult Day Programs, Supportive Housing, Assisted Living Services) to seniors at risk of frailty – but lack the resources and clinical expertise to make timely, pre-emptive interventions that could prevent loss of independence, emergency department visits or a premature move to a long-term care setting. Currently there are too many hand-offs and referral points in cases that could be addressed immediately and in consultation with a client's PCP.

The Durham Ontario Health Team has prioritized older adults living with frailty or at-risk of frailty and caregivers as one of its target populations. To address the challenges noted above, the Durham OHT has selected this initiative as one of its Year One projects. The project will implement two Community Geriatric Nursing Specialist (CGNS) positions with the goals of:

- Improving client and caregiver health outcomes and experience, while maximizing the ability to remain living independently in the community
- Enhancing rapid front-line nursing response to elderly residents living in the community who are at risk, or who have experienced, a gerontological event that may result in the loss of independence, hospitalization, or a move to a long-term care setting without timely intervention
- Building capacity in the primary health care and community health care sectors that aligns with the evolution of the Primary Community Care Hubs (PCCH) as envisioned by the Durham OHT
- Effectively and efficiently streamlining appropriate referrals to specialized services, as well as initiating assessment, and care plans to facilitate care in advance of pending in-depth interventions
- Evaluating the effectiveness of the function to inform future spread of the services.

It is anticipated that this strategic nursing investment in the CSS sector will create tangible improvements in system capacity that are already present and can be further leveraged.

RATIONALE

In addition to the ongoing monitoring of the Key Performance Indicators (KPIs)[2], the CGNS model would also benefit from a vigorous developmental evaluation (DE). DE is a type of evaluation that supports real-time, adaptive learning. It is suitable for initiatives with multiple stakeholders, high levels of innovation &/or complexity, fast paced decision-making, and areas of uncertainty[3]. Through DE, insights will be gathered to facilitate timely CGNS model refinement, test assumptions, and to identify promising practices for permanent adoption.

[2] Performance Measurement Plan under development

[3] Adapted from Patton, 2008

EVALUATION METHODOLOGY

A brief overview of the evaluation methodology is described below:

1. **Evaluation Type:** Developmental Evaluation
2. **Evaluation Question:** Which elements of the innovative CGNS model can be permanently adopted **and** recommended for expansion and spread?
3. **Evaluation Methods:** The CGNS model will be evaluated using the following criteria[4]:
   i. **Operational barriers and facilitators** for the key processes identified in *Appendix 1- Driver Diagram*
   ii. **Quality of service:**
      - Client, Care partner and Provider Experience
      - Observed Practice Feedback
   iii. **Response Times**

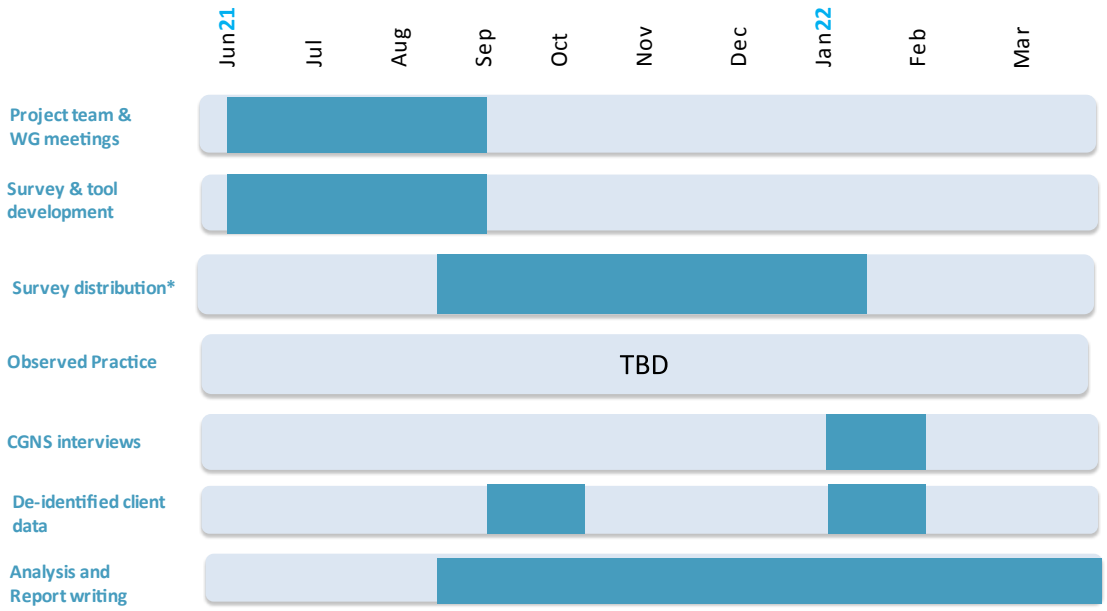
[4] Criteria and monitoring mechanisms may evolve as understanding of the processes deepens

4. Evaluation tools and data sources

#	Tools and data sources	Description	Responsibility
1	CGNS Project Team and Working Group meetings	Seniors Care Network staff will leverage meeting discussions to identify: i. Operational barriers & facilitators ii. Emerging practices iii. Opportunities for quick course-correction and ongoing improvement	i. Seniors Care Network ii. Meeting participants (including CGNS and GEM leadership)
2	Surveys	i. Client and Care partner surveys ii. Provider[5] (i.e., CSS staff, primary care providers (PCP), Virtual Urgent Care Clinic (LHO), clinicians, etc.) surveys	i. Seniors Care Network to lead the development of surveys ii. CGNS and participating CSS providers to distribute surveys iii. Seniors Care Network to analyze survey data
3	CGNS interviews	To determine: i. Onboarding and ongoing training needs ii. Model strengths and limitations iii. Recommendations for model sustainability and expansion, etc.	Seniors Care Network to: i. lead the development of interview questions ii. conduct interviews iii. analyze data
4	Observed Practice	To determine: i. Quality of assessment ii. Ongoing training needs	i. Seniors Care Network ii. GEM leadership
5	De-identified client data	To determine: i. Average clinician response times including (but not limited to): • Time from referral to initial CGNS assessment • Time from triage to initial CGNS assessment • Time from initiation of communication with PCP/ Virtual Urgent Care Clinic (LHO), clinician (post CGNS assessment) to collaborative consultation ii. Other parameters as deemed necessary	Seniors Care Network to: i. develop the audit tool and data collection plan in collaboration with CGNS ii. analyze collected data

[5] Only those providers who have been involved in the CGNS process

5. Draft Timeline:



**Client and Care partner Survey data will be collected on an ongoing basis. Provider Survey data will be collected on an episodic basis; timeline will be finalized upon discussion with participating CSS Providers*

Final Deliverable

Developmental Evaluation Report and Recommendations.

Operational Barriers and Facilitators

Table 1

	Facilitators	Barriers
Structures *(attributes of the setting in which the program occurs[6])*	• Host agency infrastructure in place to receive internal and external referrals • Host agency provided in-kind contributions to enable CGNS service implementation such as, IT, admin support, HR, etc. • Subject Matter Expertise from the CGNS Project Team; well- connected group, clinician and client/care partner, and CSS partner organizations' representation • Project Management support to kick-start the project • Brock CHC provided clinical supervision • **Non-NP role:** avoided carrying unattached client caseload	• **Non-NP role:** hindered ability to independently manage patients; reliance on other clinicians for diagnosis, medication prescriptions, diagnostic & lab work, and issuance of referrals to specialist(s) • **Hiring delays:** Unforeseen delay in hiring the second CGNS staff hindered offering services to higher capacity early on • **Connecting ON access**: untimely access to Connecting ON hindered triage and assessment process • **Host agency Management turn-over** • **Lack of on-site clinical oversight/mentorship**
Processes *(what is actually done in the giving and receiving of care[5])*	CSS partner onboarding: 3-step process co-developed with partners	**COVID-related delays** with onboarding new partners; lower pool of target clientele
	Referral: Streamlined/efficient process with enablers in place (i.e., fax, electronic referral systems, etc.)	• **Referral criteria:** Unclear to selective front-line staff; original training deck elaborating referral/suitability criteria was too detailed. However, quick reference guides were developed, and scenarios were included in the training deck upon receiving feedback. • **Low referral volumes** (further elaborated under the section 'Evaluation of low referral volumes and referrals outside the intended referral criteria') • **Referrals outside of the intended scope** (further elaborated in section 4a)
	Triage: Target turn-around-times established and met. However, it should be noted that referral volumes were very low	• Delayed/no contact from CGNS to PCP (early stages of the project) • Delayed/no contact from PCP to CGNS
	Assessment and Intervention:	• Delayed/no contact with/from PCP • non-NP role: hindered ability to independently manage patients; there

[6] Donabedian, A (1966). Evaluating the Quality of Medical Care. Millbank Quarterly, 44(3), 166-206

	Facilitators	Barriers
	• Geriatric Emergency Medicine (GEM) involvement in initial CGNS training on targeted geriatric assessment • Brock Community Health Centre (CHC) NP oversight • Process enabled follow-up • Process clearly outlined steps to be followed when encountering patients experiencing acute emergencies	was reliance on other clinicians for diagnosis, medication prescriptions, diagnostic & lab work, and issuance of referrals to specialist(s)
	Discharge: Criteria developed and implemented	**Delayed discharge:** collaborative consultation with PCP delayed/inadequate
	Quality Improvement (QI): QI and DE lens adopted through every phase of the project to identify areas of improvement and minimize risks. Tools/methods used included: Driver diagram, FMEA, RCA, impact-effort matrix, retrospective chart review analysis, etc.) See Appendices 1, 2 & 3, and the section 'Evaluation of low referral volumes and referrals outside the intended referral criteria' below, as examples.	• Opportunities for quick course-correction (further elaborated under the section 'Evaluation of low referral volumes and referrals outside the intended referral criteria') and ongoing improvement were often not adopted due to various factors • QI tools although initiated but not always updated as proposed (e.g., project aim statement in the Driver Diagram- Attachment 1 was not finalized)
	Performance Measurement: Development of indicators, data-dictionary, data collection template, etc.	--

Client and Care Partner Experience

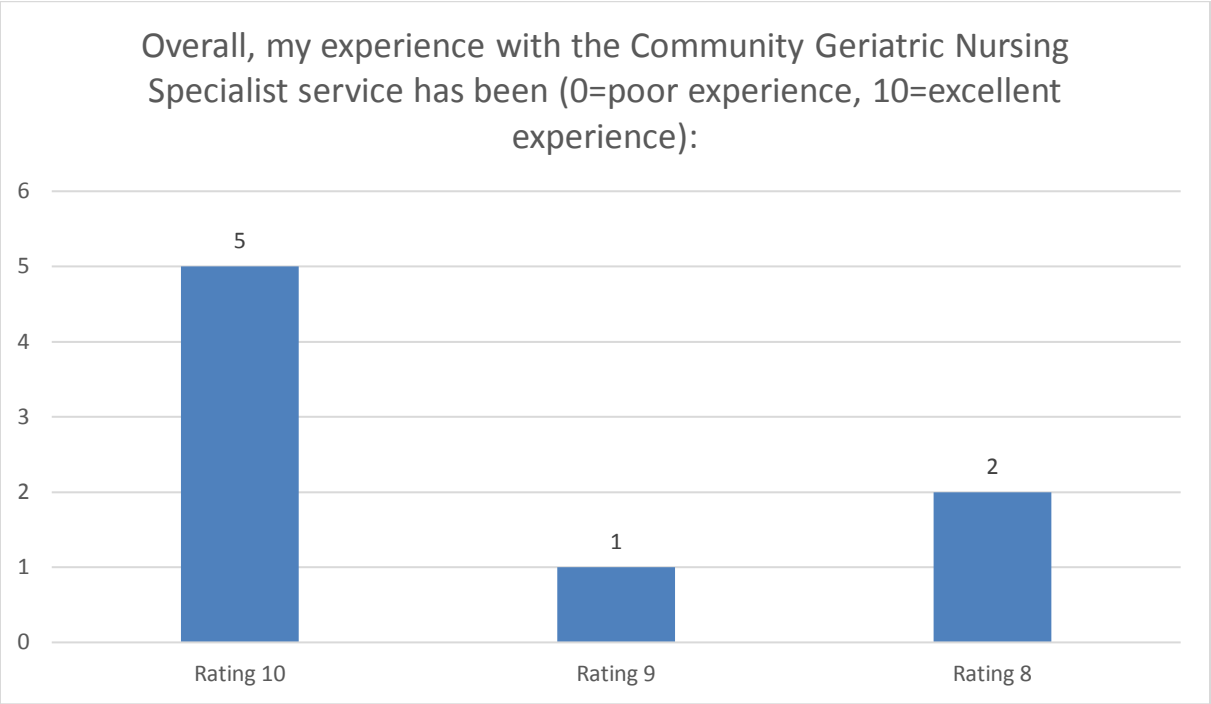
Client and Care partner experience was evaluated through surveys. Participation in the anonymous experience surveys was voluntary. Responses were submitted online and through hard copies of the surveys. Responses received through the hard copies were entered in the Survey Monkey software by the evaluators. Entered data was exported to a Microsoft Excel (v.16.43) file. Data was cleaned and analyzed in Excel.

a) Client Survey

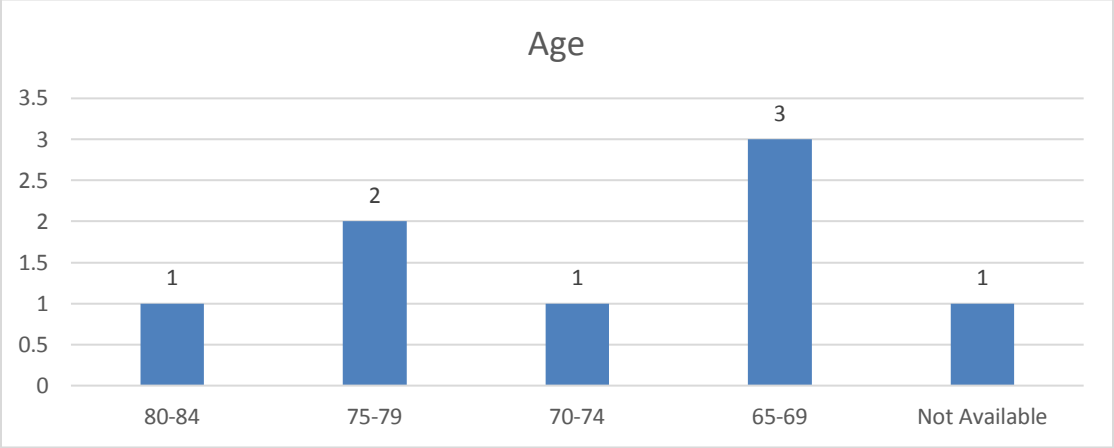
The client experience survey comprised of 21 questions (See Appendix 4). It was a combination of multiple-choice, Likert scale and open-ended questions. The survey was in English. Since the clients were expected to fill the survey on their own, the exclusion criteria included advanced cognitive impairment and/or 'unstable' condition at the time of discharge. There was a total of 8 survey respondents (as of Feb 2022). Due to low response rates the findings should be interpreted with caution. The following table and graphs provide a summary of the responses.

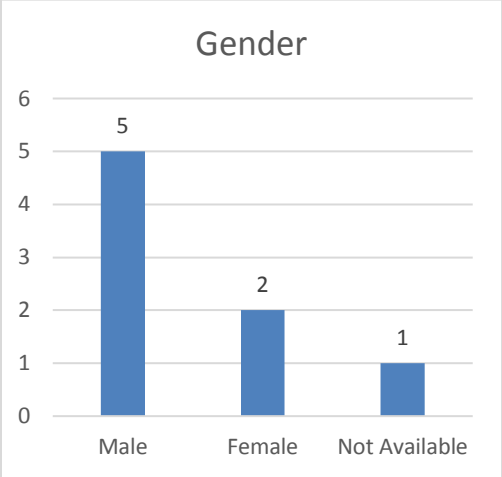
Table 2- Client Survey Summary

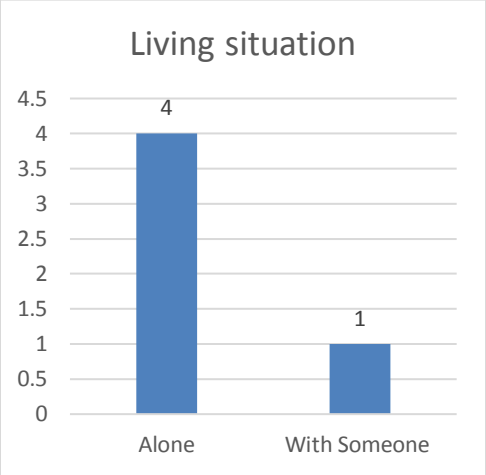
Yes/No Questions	Yes (n)	No (n)
My first visit was within 2 business days of my initial phone call with the nurse	8	0
I was told to call 911 or go to the Emergency Department if my condition worsened while waiting for my first visit	7	1
My health concern was addressed	8	0
Information was given to me in a way I could understand	8	0
I received the information I needed	8	0
I was treated with respect	8	0
I was treated with kindness	8	0
I was included in making decisions about my care, as much as I wanted to be	8	0
I was referred to other programs/services if I needed to be	8	0
It was clear to me who would receive information about my care	8	0
I received information about what symptoms or health problems to look out for at the time of discharge	7	1
I would recommend this service to family or friends if they needed it	8	0



Demographic data







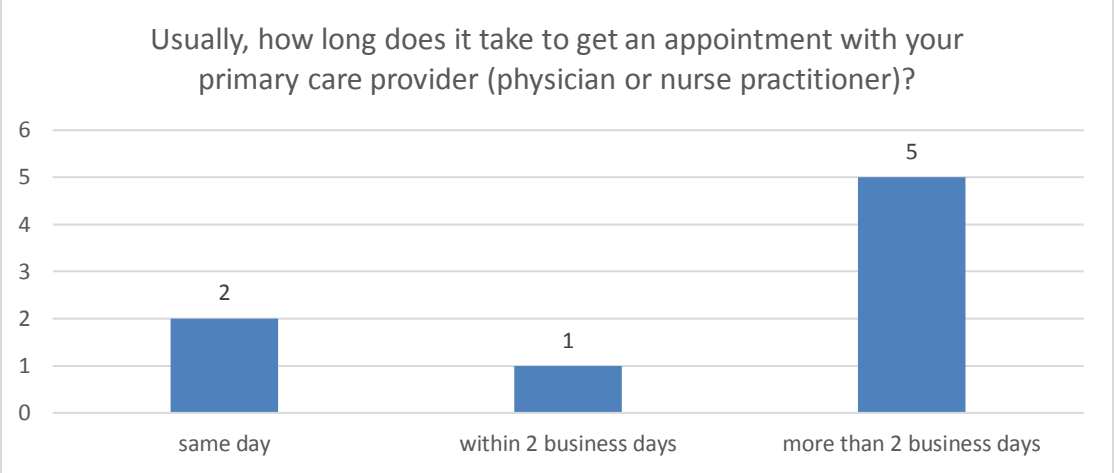


Table 3- Responses to Open-ended Questions

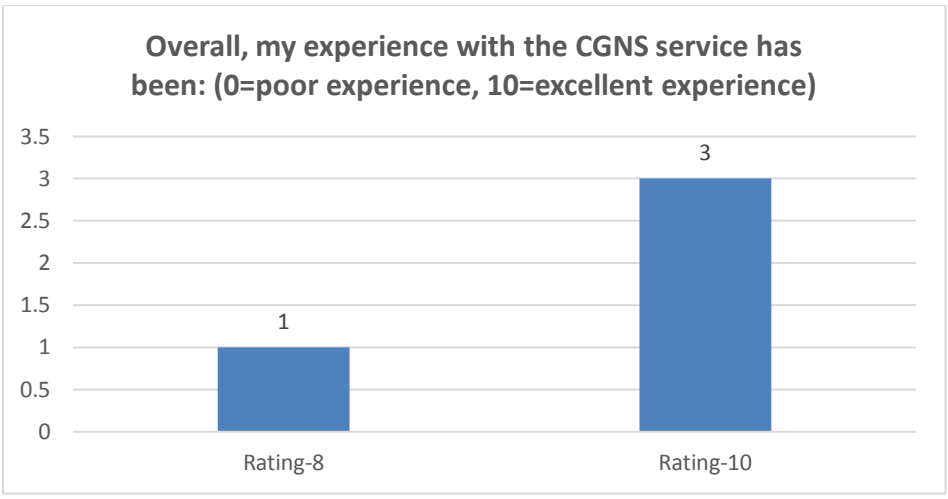
What worked well	n
Great communication (including information on next steps)	2
Regular visits and follow-ups	2

b) Care Partner Survey

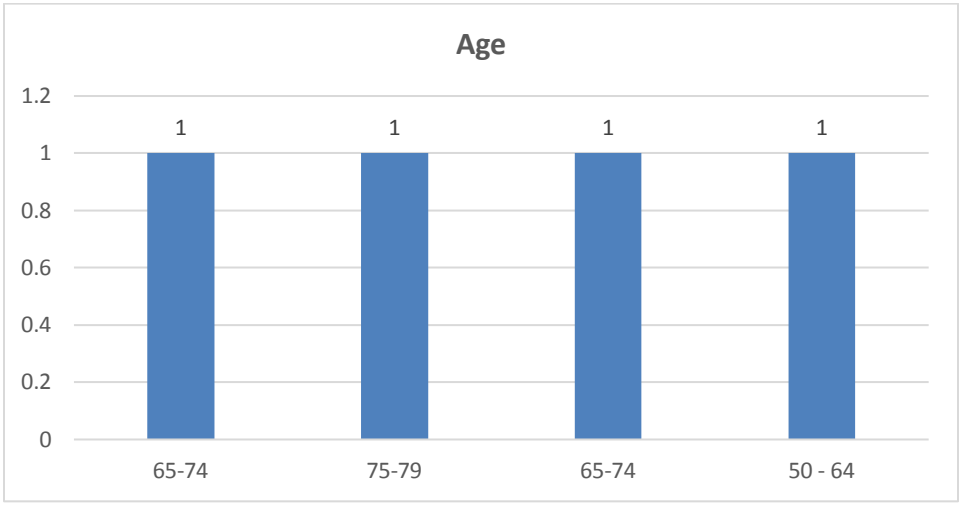
The care partner experience survey comprised of 16 questions (See Appendix 5). It was a combination of multiple-choice, Likert scale and open-ended questions. The survey was in English. The survey was only offered to those care partners who were involved in the assessment and care planning process. Additionally, the survey was not offered if the client's condition was deemed 'unstable' at the time of discharge. There was a total of 4 survey respondents (as of 31st Dec 2021). Due to low response rates the findings should be interpreted with caution. The following table and graphs provide a summary of the responses.

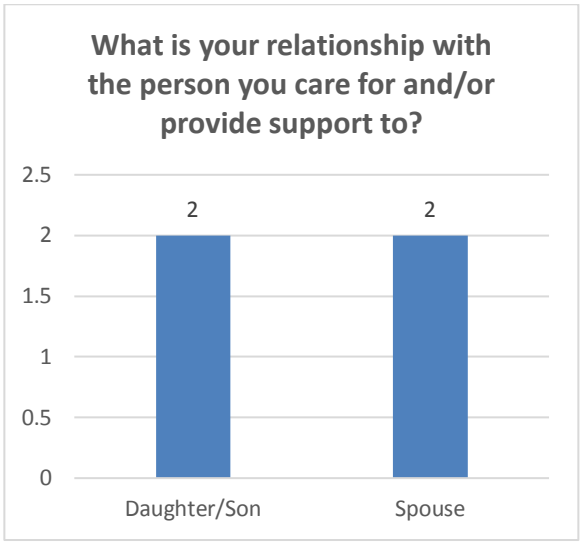
Table 4- Care partner Survey Summary

Yes/No Questions	Yes (n)	No (n)
I was treated as a source of knowledge for the person I care for and/or provide support to	4	0
I was involved in decision making with or for the person I care for and/or provide support to (to the extent they wanted me to be)	4	0
I was asked how I was coping with my care partner responsibilities	4	0
I received information that helped me in my role as a care partner	4	0
Information was given to me in a way I could understand	4	0
I was treated with respect	4	0
I was treated with kindness	4	0
The nurse was available to talk to me if I had concerns or questions	4	0
I would recommend this service to family or friends if they need it	4	0



Demographic data





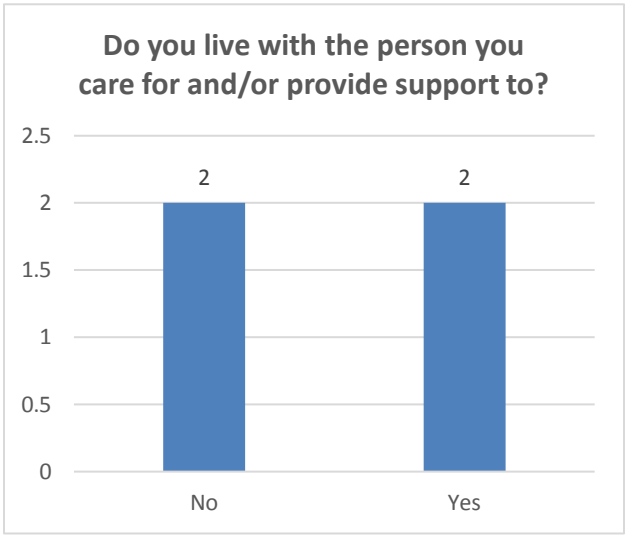


Table 5- Responses to Open-ended Questions

What worked well?	What could be improved?	Is there anything else that you would like to share?
• Excellent communication • The fact that they came to the house • [CGNS] is a very caring, exceptional nurse. She was very concerned about my mom's overall health and well-being, and eager to make and follow-up on referrals to resource services and meaningful supports. [CGNS] is a kind, warm soul, who instantly became someone who I could depend on! Thank you! • The information we received about memory clinic	• Nothing that I know of • That they should wash their hands when arriving. I showed them the bathroom……used sanitizer after I said about washing your hands • We were shown what we should do next with respect to health of my spouse……no improvement needed at this time	• Our nurse was outstanding! • I feel like I have some support to help my spouse deal with his situation and I also have somewhere to reach out to • Very pleased with the quick response of help for us…. Nurse very easy to talk to……what she said she would do, she did.

Chart Review Analysis

Data was collected in Dec 2021 (sample size=33) by the CGNSs using a template. Submitted data and was reviewed and analyzed by the evaluators using Microsoft Excel (v.16.43).

#	Indicator	Yes (n)	Yes (%)
1	**Triage response time:** Percentage of triages initiated within 6 business hours of the receipt of referral	29/33	88%
2a	**Target clientele:** • Percentage of clients requiring a CGNS visit for a sudden and unexpected change	2/33	6%
2b	• Percentage of clients for whom a CGNS visit was conducted	24/33	73%
3	**Collaborative consultation:** Percentage of clients for whom the Primary Care Provider (PCP) was consulted prior to initial visit	Zero/24*	--
4	**Target time for initial visit:** Percentage of clients for whom initial visit was conducted within 2 business days of triage	20/24	83%
5	**Collaborative consultation:** Percentage of clients for whom the care plan developed in collaboration with the PCP	11/33	33%
6a	**Repeat referrals:** Percentage of clients for whom a repeat referral was received within 30 days of discharge	1/33**	33%
6b	**Percentage of re-referrals where the reason of referral/presenting complaint was same to the initial referral**	Zero/1	--

**1 client was unattached **30 days not reached for 2 clients at the time of data collection*

A thematic analysis of the comments was also conducted to attain a better understanding of the collected data. Key findings for select indicators are summarized below:

Indicator 2a - Percentage of clients requiring a CGNS visit for a sudden and unexpected change	
Themes for 'No' option (reasons for referral)	**#**
Acute issue, refused to go to hospital	1
Chronic issues; ongoing disease management	26
Client ineligible due to being served by HISH program	1
Required system navigation	1
Chronic issues; already supported by other clinicians	1
Reason for referral already investigated by primary care and referrals sent to specialists for further investigation	1

Indicators 2b- Percentage of clients for whom a CGNS visit was conducted	
Themes for 'Yes' option:	**#**
Expectation to visit client	18
Out-of-scope but for test-run	1
Valid	2
No reason provided in the comments section	3

Indicator 3- Percentage of clients for whom the Primary Care Provider (PCP) was consulted prior to initial visit	
Themes for 'No' response:	**#**
Late response from PCP	2
No response (1 letter, 1 letter and call sent/made to PCP)	2
No reason provided in the comments section	19

Indicator 4- Percentage of clients for whom initial visit was conducted within 2 business days of triage	
Themes for 'No' response:	**#**
Delay from client/care partner	4

Indicator 5- Percentage of clients for whom the care plan developed in collaboration with the PCP	
Themes for 'No' response:	**#**
No identified need	2
Daughter to f/u with PCP and/or virtual urgent care and/or ED if needed	1
No response from PCP	16
PCP got involved before CGNS could intervene - PCP deemed client palliative	1
Son encouraged to f/u with PCP, recommendation and ax shared with PCP, no response, client was admitted to hospital and discharged from service	1

Evaluation of low referral volumes and referrals outside the intended referral criteria

a) Root Cause Analysis

A short online survey (See Appendix 6) was developed to attain a better understanding of the potential reason(s) for low referral volumes and the receipt of referrals outside the intended referral criteria. The link was shared with members of the Project Team, who in-turned distributed it to their agency staff (where applicable). A summary of the findings is summarized below:

- Data collection period= Oct 3 to Oct 15, 2021
- Total survey responses = 25
  - Staff member of a CSS partner organization = 24
  - Non-CSS partner organization member of the CGNS Project team= 1

Key findings:

- The two most frequently selected reasons for low CGNS referrals were: 1) clients in the onboarded programs are not experiencing sudden/unexpected changes in health status (n=11), and 2) clients are adequately supported by other services i.e., PCP, specialists, live-in assistance, etc. (n=9)
- Clients not experiencing sudden/unexpected changes in health status was also the most frequently selected reason for why referrals are being made outside the intended suitability criteria (n=14), followed by 'unclear suitability/eligibility criteria' (n=8)
- Provision of additional training (n=11) and helpful tools (n=4) were the top two proposed solutions to support frontline staff in identifying appropriate clients
- Foot care, Meals on Wheels (MOW) and Respite (n=2 each) were the most recommended internal programs/services to which the CGNS service could be expanded to. Two (2) survey-takers also recommended expanding the service throughout/within ASDR
- Majority of the responses suggested that CGNS should consider accepting referrals from other Oshawa-based clinicians. Top recommendations included PCP (n=8), GEM (n=7) and PSW (n=2)
- Frequently proposed additional steps that could increase referrals to CGNS included: 1) changes to/clarity regarding the 'referral form or process' (n= 5), and 2) 'increasing awareness about the program' (n=4)

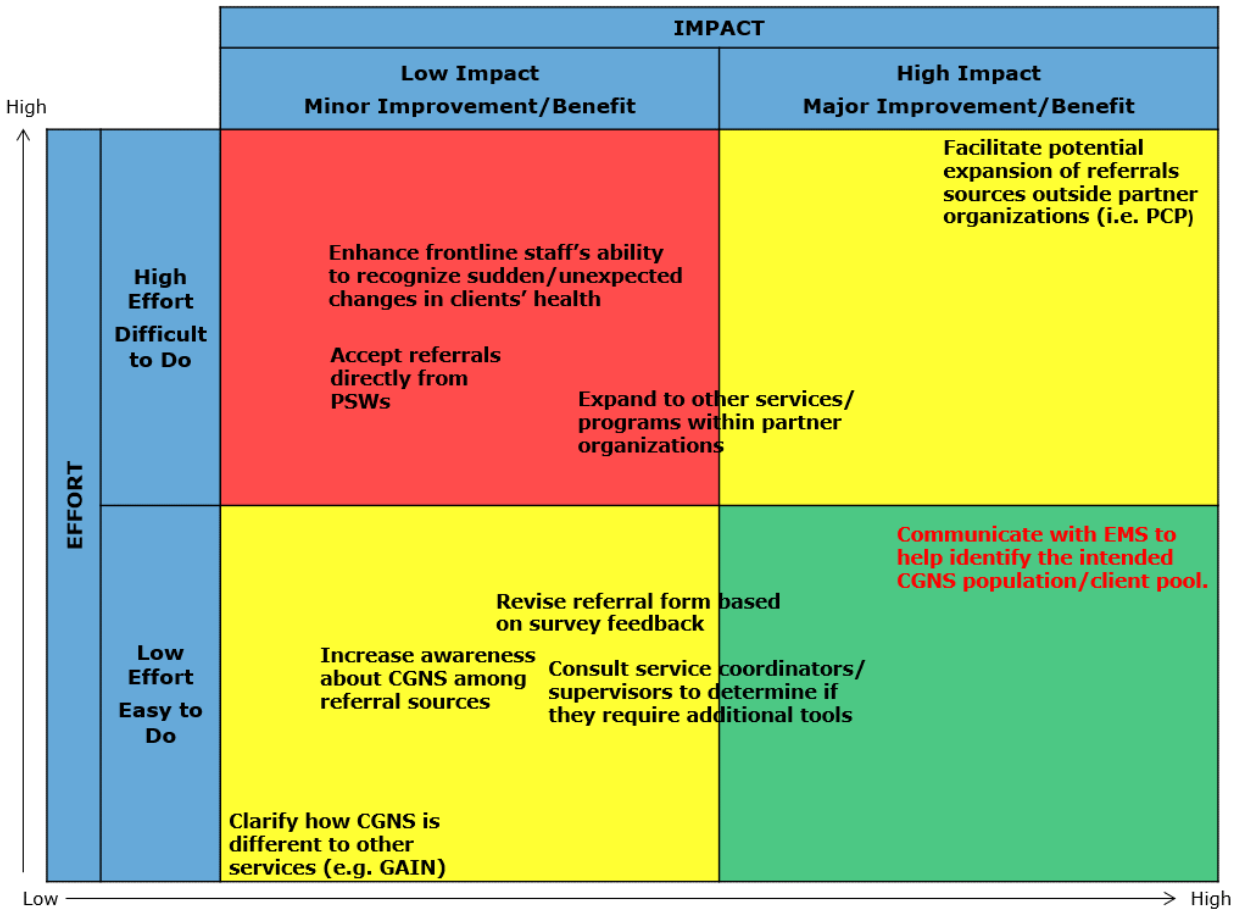
Recommendations made:

- Consider accepting referrals directly from Personal Support Workers (PSWs)
- Revise referral form based on survey feedback
- Expand to other services/programs within partner organizations (e.g., Meals on Wheels (MOW), Foot care, Respite, and across Alzheimer's Society of Durham Region (ASDR))
- Enhance staff's ability to recognize sudden/unexpected changes in clients' health through additional training & tools
- Consult Service Coordinators/Supervisors to determine if they require tools in ruling out emergency situations at time of initiating referrals (e.g., delirium, neurological events, etc.)
- Clarify how CGNS is different to other services (e.g., Geriatric Assessment and Intervention Network (GAIN))
- Facilitate potential expansion of referral sources outside partner organizations (i.e., Primary Care Providers (PCP)) by initiating conversations with a large Oshawa-based Family Health Team to confirm need
- Increase awareness about CGNS among referral sources
- Communicate with Emergency Medical Services (EMS) to help identify the intended CGNS population/client pool

b) Prioritization of recommendations utilizing the Impact Effort Matrix

The proposed recommendations were jointly reviewed by a small working group. Each of the recommendation was evaluated based on the perceived effort and resulting impact in improving volumes of appropriate referrals to CGNS. See Figure 1:

Figure 1- Impact Effort Matrix



It was decided to prioritize communicating with EMS to help identify the intended CGNS population/clientele. Seniors Care Network arranged an introductory meeting with Community Paramedicine. All meeting members agreed there was potential for collaboration to enhance referrals to CGNS. The collaboration could also result in initiation of interventions by Community Paramedicine (e.g., point-of-care testing, medication administration, etc.). It was agreed to meet again in January 2022. The meeting was to be organized by the host agency. However, the meeting was not conducted.

During subsequent CGNS Project Team meetings, it was recommended to also initiate conversation with a FHTs/primary care practice to explore the benefit of receiving referrals from PCPs directly. A potential practice was identified by a Project Team member, however, the recommendation was not followed through.

Provider Experience

The below table summarizes the results of interviews with staff (partner agency and host agency):

Table-6

Questions	Comments
What worked well?	• Although majority of the clients seen did not fall within the intended referral criteria, the CGNS service did add value • Project team members collaborated and met frequently which led to relationship building/strengthening among partners • CGNS attended the training session at a CSS partner site, which allowed the partner agency to adapt the training to their needs/context • Introductory CGNS visit to the site was well received by clients
What did not work well? What could have been done differently?	• Lack of clinical supervision at host agency • Lack of prescribing/diagnostic privileges (i.e., non-NP role) • Management turn-over at host agency leading to lack of clear direction • Lack of clarity between the role of Project Manager and host agency Manager/Supervisor • There seemed to be a training gap; CGNS seemed less familiar with the context of 'community' nursing • Some P&Ps seemed less familiar/unclear to the CGNS, e.g., those pertaining to liability insurance, documentation, aspects of information sharing within circle-of-care, etc., and clarification was sought rather late in the project • Communication with PCP was inadequate/infrequent • There was disconnect between the decisions made by the Project Team and what was reflected on the referral form, which led to lack of clarity, e.g., 'care partner stress' was included among the reasons for referral • PCP representative was not a part of the Project Team • There were instances of delayed information-sharing with the Project team
Recommendations for OHTs or other planners if they want to implement a similar model in the CSS sector?	• CGNS should be embedded within a Family Health Team (FHT) or Community Health Centre (CHC), with virtual supports that can help to 'lay eyes' on a client; consider collaboration with specific PCP practices/clinics (CHCs, FHTs, etc.) to cater to their clients, rather than serving an extensive geographical area with multiple PCPs • Provision of onsite clinical support; however, this may not be needed if the CGNS has NP designation • Timely availability of IT enablers such as, Connecting ON, virtual platforms, etc. • Leverage learnings from existing models of care, e.g., Geriatric NP service at Brock CHC
Additional Comments	The project validated that clients in Adult Day Programs, Supportive Housing and Assisted Living Services already receive a lot of support; maybe we are missing those that are not attached to CSS.

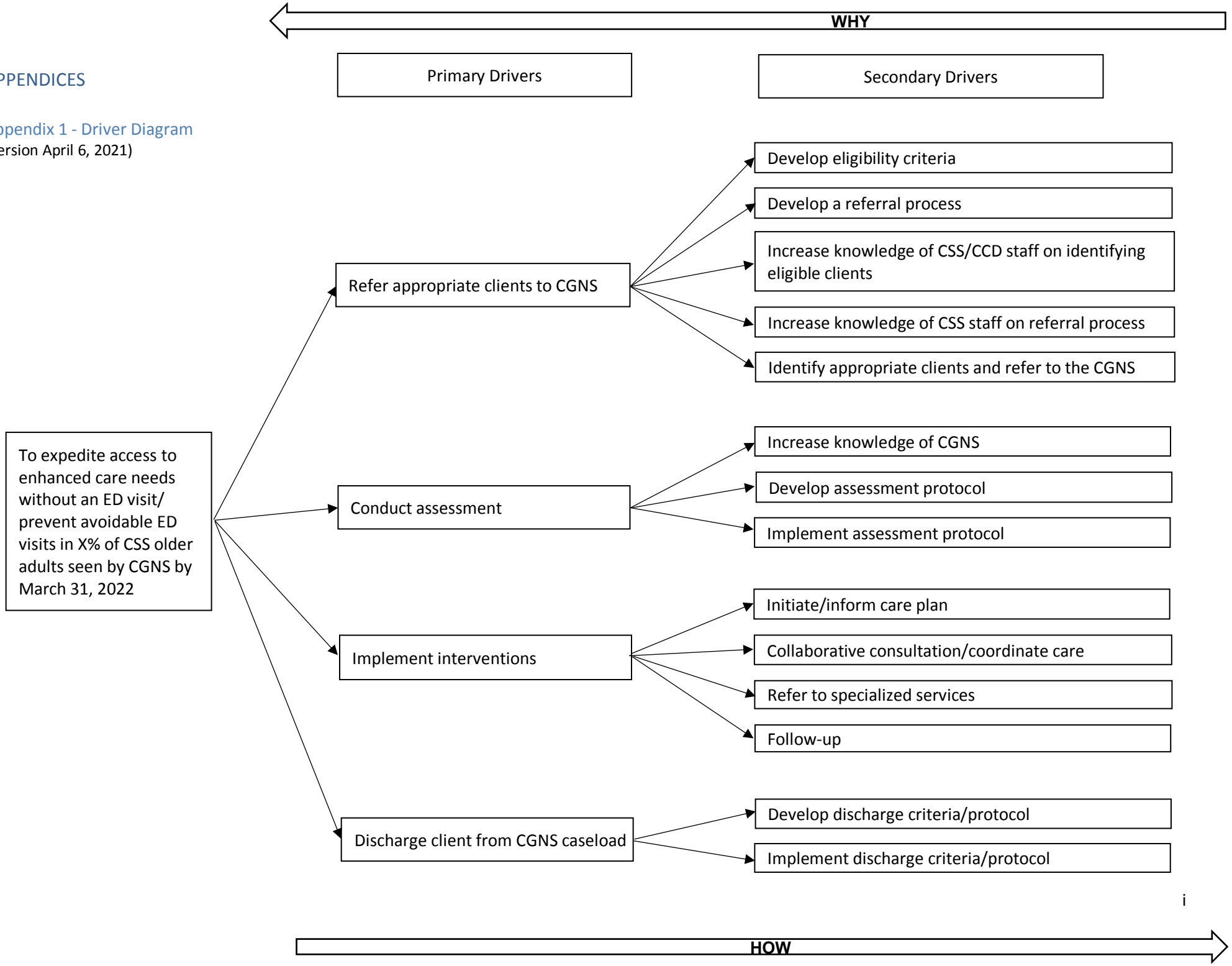
RECOMMENDATIONS IF THE EXISTING SCOPE OF THE CGNS SERVICE CONTINUES

- Utilize data to help inform the need for a CSS-based nursing service for older adults experiencing a sudden or unexpected change in their condition
- Collaborate with Emergency Medical Services to identify the clientele that may best benefit from services like CGNS
- Communicate with other Durham OHT sub-groups/committees to identify synergies among existing and/or prospective older adult-focused projects and initiatives (e.g., Community Paramedicine, Virtual Urgent Care, Seniors Urgency Room, etc.) to explore collaboration
- Consult with key stakeholders such as PCPs prior to (re)initiating
- Eliminate structural barriers identified in Table 1 such as:
  - hiring staff with diagnostic and prescribing privileges i.e., NP role
  - timely access to electronic information systems such as Connecting ON,
  - on-site clinical supervision
- Follow-up on recommendations made by the Project Team including opportunities for quick course-correction identified by the Developmental Evaluation such as, identification of the appropriate clientele (through EMS, ER utilization data, etc.) and expansion of referral sources (e.g., PCP and GEM referrals outside of Supportive Housing).

APPENDICES

Appendix 1 - Driver Diagram

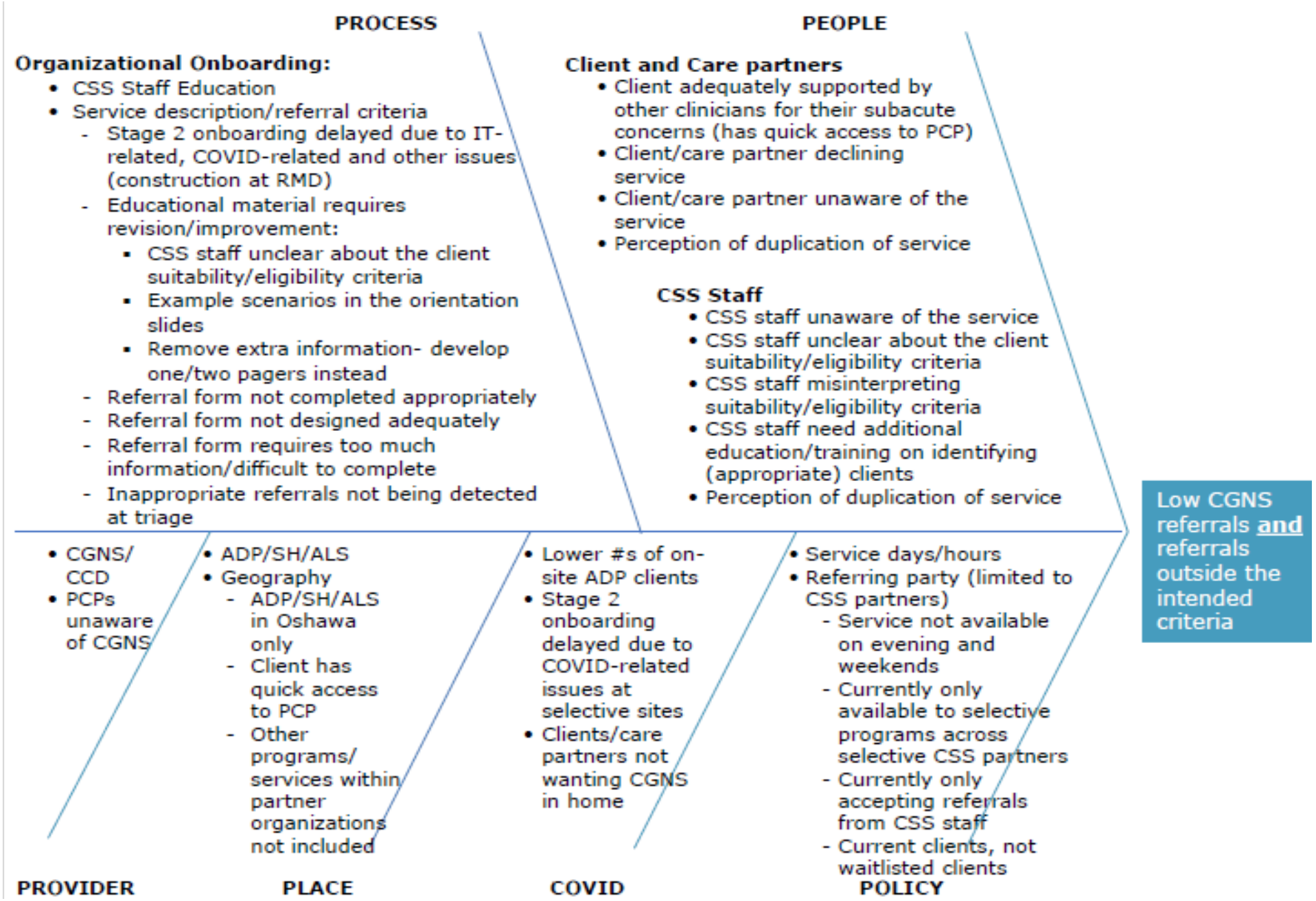
(version April 6, 2021)



Appendix 2 - Failure Mode and Effect Analysis (FMEA)

Process Step	Potential Failure Mode	Potential Failure Effects	Potential Causes	OCC	DET	SEV	RPN	Actions Recommended	Responsibility	Timeline	OCC	DET	SEV	RPN
What is the process step?	In what ways can the process step fail (go wrong)?	What is the impact?	What are the causes?	Likelihood of Occurrence	Likelihood of Detection	Severity	Risk Priority Number	What are the actions for reducing the Occurrence or improving Detection?			Likelihood of Occurrence	Likelihood of Detection	Severity	Risk Priority Number
Referral Receipt	Internet down	CGNS not able to receive referral	System outages	1	8	9	72	Mail on CGNS		Completed				
		Incomplete/inaccurate/out of date information, misinfomation	record system out of date, get clarification,	2	2	10	40	educate referral source staff, obtain clarification at triage		Ongoing				
		Delay in services, condition worsens, client unsure of what to do	Referral received after hours or late the day before a weekend or stat holiday	5	1	10	50	automatic reply (pending IT), info on referring form, educate referring party, shift hours of work on Fridays or prior to stat holidays,		Ongoing - Pending IT and tbd based on volumes and patterns				
		Inappropriate referrals	Partner lack of knowledge or understanding of the program, low demand	5	1	6	30	educate partners, onboard existing partners, expand throughout Durham Region, increase referral source, case finding		Ongoing, job aids and case scenarios developed				
CCD Intake		Delay in response	shortage of staff, technical difficulties, referral missed, missing information	3	5	10	150	mandated fields, staff back-up, over the phone referrals, back-up fax referrals,		Ongoing pending Caredove implemenation, Central Intake				
Triage	Delayed triage response time	Client's condition worsens	target response time not set, CGNS is busy, target response time not met, unable to contact client/care partner	6	6	10	360	Target response time within 6 hours, assign am and pm times, save 1 vacant client slot each day, office staff to facilitate contact, contact referring party to connect with client and document, educate referring party,		Completed (refer to Nursing Protocols)				0
	Delayed triage response time on Fridays/stat holidays	Client's condition worsens	service only available during business hours, unable to reach client/care partner, (caseload)	8	7	10	560	automatic reply (pending IT), info on referring form, educate referring party, shift hours of work on Fridays or prior to stat holidays,		Completed (Note: Regarding hours of work, tbd based on volumes and				0
	Triage unable to determine client experiencing an acute episode	Client's condition worsens	Client/family over reaction, client/care partner not sharing relevant information	4	8	10	320	Inform client/care partner to call 911 or go to the ED and contact referring party to facilitate ED transfer, prioritize visit, ask probing questions, obtain collateral information		Completed (refer to Nursing Protocols)				
	Visit target time not met due to client/care partner related factors	Client's condition worsens	Client/care partner not understanding urgency	8	2	6	96	add script to triage to educate clients		Completed (refer to Nursing Protocols)				0
		Client's condition worsens	Language barrier	3	1	10	30	utilize care partner, staff, translation services		Completed				
	Unable to connect with the primary care practitioner at triage for attached clients	Unable to obtain a relevant clinical picture relevant to the referral	PCP does not return call	5	1	6	30	Stakeholder education, relationship building, mechanism for quick access to PCP		Ongoing - Stakeholder Relationship Building				0
	Consent not obtained for collateral informaiton	Non-compliance with consent policy	Lack of clarity/information	6	1	8	48	Train staff, educate client/care partner						
Visits Client	Client not seen/not found	Missed visit	Client concerned about outcome of visit (e.g., referal to long term care), client forgot, out, did not hear, in medical distress , etc.	2	1	10	20	Follow not seen/not found policy, provide reminder, follow-up with the referral source						0
	Unsafe environment observed upon arrival	CGNS cancel visit	CGNS concerned about safety	2	1	8	16	Conduct safety assessment at triage,use situaltional awareness (refer to CCD HV policy)						
		Client's condition worsens	Language barrier	3	1	10	30	utilize care partner, staff, translation services						
Conducts Assessment		Client's condition worsens	Client experiencing acute episode	5	1	10	50	Follow emergency protocols, call 911, facilitate ED transfer						0
		Client refuses assessment	Client preference, client lacks insight, client not understaning urgency	2	1	8	16	educate client, end visit, update referral source and primary care						0
ED Transfer Required - client refuses		Risk of complications or death	Client preference, client lacks insight, client not understaning urgency, fear of hospitalization and/or move to LTC	5	1	10	50	educate client, offer virtual solution, update referral source and primary care, for attached clients arrange conversation with PCP		Completed (refer to Nursing Protocols)				0
Develops care plan - PCP reliant intervention		Delay in PCP response	PCP disagrees, unable to contact PCP	4	1	9	36	Stakeholder education, relationship building, mechanism for quick access to PCP, contact VUCC, refer client to walk-in clinic, facilitate ED transfer		Ongoing - Stakeholder Relationship Building				0
Implement care plan		Client not compliant with care plan	lack of insight	2	1	9	18	develop care plan in collaboration with client/care partner						0
Follow-up visit	Client not seen/not found	Missed visit	Client concerned about outcome of visit (e.g., referal to long term care), client forgot, out, did not hear, in medical distress , etc.	2	1	10	20	Follow not seen/not found policy, provide reminder, follow-up with the referral source, reschedule visit,						0
	Unsafe environment observed upon arrival	Client cancels visit	Client preference, client not available	2	1	8	16	decide if visit still required, reschedule visit, follow-up with referral source, educaate client, consider discharge						0
Reassess client		Unable to stabilize client	Care plan not effective, client condition worsens	5	1	9	45	consult with PCP, VUCC, ED transfer if required		Completed - Same as response to acute situation as detailed in Nursing protocols				

Appendix 3 - Fishbone



Appendix 4 - CGNS Client Experience Survey

COMMUNITY GERIATRIC NURSING SPECIALIST
CLIENT EXPERIENCE SURVEY

(CCD logo)

Date (to be filled by the Nurse) _____
MM/DD/YYYY

Thank you for taking the time to complete this survey. Your anonymous feedback about your experience as a client with the Community Geriatric Nursing Specialist service will help us improve our care and services. Participation in the survey is voluntary. Your responses will be kept confidential. Returning this survey implies your consent to participate in this survey's analysis. This survey is to be completed by you, the **client**. However, someone (e.g., family member, friend or care partner) may physically assist you, if needed.

	Please read the statements below and circle the answer to the right that best describes <u>your experience</u> with the service	
1	My first visit was within 2 business days of my initial phone call with the nurse	Yes No
2	I was told to call 911 or go to the Emergency Department if my condition worsened while waiting for my first visit	Yes No
3	My health concern was addressed	Yes No
4	Information was given to me in a way I could understand	Yes No
5	I received the information I needed	Yes No
6	I was treated with respect	Yes No
7	I was treated with kindness	Yes No
8	I was included in making decisions about my care, as much as I wanted to be	Yes No
9	The nurse was available to talk to me if I had concerns or questions	Yes No N/A*
10	I was referred to other programs/services if I needed to be	Yes No N/A*
11	It was clear to me who would receive information about my care	Yes No
12	I received information about what symptoms or health problems to look out for at the time of discharge	Yes No
13	**I would recommend this service to family or friends if they needed it**	Yes No
14	**Overall, my experience with the Community Geriatric Nursing Specialist service has been:** 0 1 2 3 4 5 6 7 8 9 10 (0=poor experience) (10=excellent experience)	

***N/A= Not Applicable** **PLEASE TURN THE PAGE OVER FOR REMAINING QUESTIONS**

15	**What worked well?**
16	**What could be improved?**
17	**Is there anything else that you would like to share?**

Please provide the following information:

My Age:

□ under 65 □ 65-69 □ 70-74 □ 75-79 □ 80-84 □ 85-89 □ 90-94 □ 95+

I identify as:

□ Woman □ Man □ Gender-fluid, non-binary, and/or Two-Spirit □ Prefer not to answer

What is your living situation?

□ Living Alone □ Living with someone

Usually, how long does it take to get an appointment with your primary care provider (physician or nurse practitioner)?

□ I do not have a primary care provider □ same day

□ within 2 business days □ more than 2 business days

THANK YOU!

(Add directions re: method to return completed survey to the program/clinic)

Adapted from the Regional Geriatric Programs of Ontario Older Adult Experience Survey.

COMMUNITY GERIATRIC NURSING SPECIALIST

CARE PARTNER EXPERIENCE SURVEY

CCD logo

Date (to be filled by the Nurse) _____

MM/DD/YYYY

Thank you for taking the time to complete this survey. Your anonymous feedback about your experience as a care partner with the Community Geriatric Nurse Specialist service will help us improve our care and services. Participation in the survey is voluntary. Your responses will be kept confidential. Returning this survey implies your consent to participate in this survey's analysis.

	Please read the statements below and circle the answer to the right that best describes <u>your experience</u> as a care partner with the service:	
1	I was treated as a source of knowledge for the person I care for and/or provide support to	Yes No
2	I was involved in decision making with or for the person I care for and/or provide support to (to the extent they wanted me to be)	Yes No
3	I was asked how I was coping with my care partner responsibilities	Yes No
4	I received information that helped me in my role as a care partner	Yes No
5	Information was given to me in a way I could understand	Yes No
6	I was treated with respect	Yes No
7	I was treated with kindness	Yes No
8	The nurse was available to talk to me if I had concerns or questions	Yes No N/A*
9	I would recommend this service to family or friends if they need it.	Yes No
10	**Overall, my experience with the Community Geriatric Nursing Specialist service has been:** 0 1 2 3 4 5 6 7 8 9 10 (0=poor experience) (10=excellent experience)	

***N/A= Not Applicable**

PLEASE TURN THE PAGE OVER FOR REMAINING QUESTIONS

11	**What worked well?**
12	**What could be improved?**
13	**Is there anything else that you would like to share?**

Please provide the following information:

My age:

□ under 40 □ 40-49 □ 50 - 64 □ 65-74 □ 75-79 □ 80-84 □ 85-89 □ 90-94 □ 95+

What is your relationship with the person you care for and/or provide support to?

□ Spouse □ Daughter/Son □ Other, please specify:_____

Do you live with the person you care for and/or provide support to?

□ Yes □ No

THANK YOU!

(Add directions re: method to return completed survey to the program/clinic)

Appendix 6 - CGNS Referrals Survey

CGNS Referrals Survey

The CGNS project team is currently observing low referral volume. Moreover, many of the referrals received to date are not necessarily for a 'sudden/unexpected change in a client's health status or medical condition', the intended referral criteria.

We are conducting this survey to better understand the possible reasons for low referrals, and to use your feedback to develop strategies to increase referrals to CGNS.

We thank you for your time and valuable input as we continue to build the CGNS program to better support older adults living with chronic and complex conditions including frailty and their caregivers.

Instructions:

If you are a staff member of a Community Support Services (CSS) partner organization (i.e., CCD, OSCC 55+, CAH, ASDR, MOD, RMD and VON):

- **start with Question #1**

If you are a non-CSS partner organization member of the CGNS Project team:

- start with Question #6

1. Name of the Organization:

2. Has your organization been onboarded to send referrals to CGNS?

   ☐ Yes (move to Q3)

   ☐ No (move to Q6)

3. Which program(s) in our organization can send referrals to CGNS?

   ☐ Adult Day Program (ADP)

   ☐ Supportive Housing (SH) Assisted

   ☐ Living (PSW Services)

   ☐ All of above

4. Select the likely reason(s) for low referrals to CGNS (check all that apply):

- ☐ Clients adequately supported by other clinicians for sudden/unexpected changes in health status or medical condition (e.g., clients have quick access to Primary Care Doctor/Nurse Practitioner). Use the comment box below to further explain
- ☐ Clients are not experiencing sudden/unexpected changes in health status or medical condition
- ☐ Staff/I have difficulty recognizing sudden/unexpected changes in health status or medical condition
- ☐ CGNS service not available during evenings and/or weekends
- ☐ Referral form not designed adequately. Use the comment box below to further explain
- ☐ Staff/I am not aware of the CGNS service
- ☐ Staff/I perceive CGNS as a duplication of service
- ☐ Client/care partner not aware of the CGNS service
- ☐ Client/care partner declining the CGNS service
- ☐ Other. Use the comment box below to further explain

Comments:

5. From the following, select all that could lead to making referrals for reasons other than a 'sudden/unexpected change in client's health status or medical condition':

- ☐ Client suitability/eligibility criteria unclear. Use the comment box below to further explain
- ☐ Clients are not experiencing sudden/unexpected changes in health status or medical condition
- ☐ Educational slides unclear
- ☐ Other. Use the comment box below to further explain

Comments:

6. What steps should be taken to support frontline staff in identifying appropriate clients? (e.g., specific training on signs and symptoms of geriatric syndromes, frailty, education on identifying sudden/unexpected change in health status or medical condition, etc., through lunch and learn sessions, lectures, mini-quizzes, job-aids, etc.)

7. Currently CGNS is only accepting referrals from Adult Day Programs, Supportive Housing and Assisted Living/PSW Services, which additional Oshawa-based services/programs within your organization could benefit from the CGNS service?

8. Should the CGNS service consider accepting referrals from other clinicians in Oshawa (e.g., Geriatric Emergency Management (GEM) Nurses, Primary Care Physician/Nurse Practitioners, etc.)? If yes, which clinicians?

9. What additional steps could be taken to increase referrals to CGNS?

10. Is there anything else that you would like to share?

Thank you for taking time out in completing the survey. To submit click DONE