TORONTO EAST GENERAL HOSPITAL

Being Senior Friendly

Toronto East General Hospital
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Objectives

1. Discuss the Senior Friendly Strategy at TEGH
2. Discuss Mobility Program to prevent functional decline at TEGH
3. Discuss Falls
4. Memory Care Unit
5. Discuss the opening of the ACE unit at TEGH

Seniors

Senior Friendly Strategy

- Toronto East General Hospital recognizes the importance of providing services for the elderly

- Elderly population living longer and with more medically complex conditions

Senior Friendly Strategic Plan

- TEGH developed a Senior Friendly Strategic Plan based on recommendations from the Senior Friendly Hospital developed by the Regional Geriatric Program

Senior Friendly Strategic Plan

- The strategic plan involves looking at different processes within Toronto East General
  - Organizational Support
  - Processes of Care
  - Emotional and Behavioural Support
  - Ethics in Clinical Care
  - Physical Environment

Senior Friendly Steering Committee

- Overseeing the strategy is a Senior Friendly Steering Committee that includes members from all programs within the hospital and is very a interdisciplinary team

- We also have included a patient representation on our committee

Senior Friendly Steering Committee

- The mandate of the steering committee is to put into practice the strategies that will ensure that Toronto East General is building capacity with staff around senior care

Strategies at TEGH

To date we have addressed a number of different strategies within each category:

- Organizational Support
- Processes of Care
- Emotional and Behavioural Support
- Ethics in Clinical Care
- Physical Environment

Strategies at TEGH

Organizational Support

- Identified Senior Friendly "Champions "
  - CNS role
  - Corporate geriatrician
  - Hospital wide Steering Committee
  - Care for the elderly as a organizational priority
  - CNO sits on Senior Friendly Steering Committee

Strategies at TEGH

Processes of Care

- Development of delirium, Provincial Pilot Study on Delirium for the in the process of rolling out the CAM and the electronic documentation in all inpatient units that is applicable to
- Mobility Strategy
- Falls Strategy – improving current processes
- Education on Gentle Persuasive Approach in dealing with patients with responsive behaviours

Seniors Friendly Delirium Indicator Pilot on B2

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Provincial Pilot Study for Delirium Care

This pilot research study is a LHIN led Ontario Seniors Friendly Hospital (SFH) initiative on delirium care. The vision is to enable seniors to maintain optimal health and function while they are hospitalized so that they can be discharged home.

The overall objectives are to:

- ✓ Explore the feasibility of implementing the proposed delirium indicator for accountability purposes
- ✓ Identify implementation success factors and challenges

TEGH is one of 32 hospitals chosen to participate in this exciting and innovative study. B2 has been chosen as TEGH's pilot unit. The study ends January 2014.

Delirium is a new onset of confusion and is caused by un-treated conditions such as pain/ low oxygen/ infections etc.

The Purpose of the Study

The purpose of this study is to determine:

- The percentage of patients (65 and older) receiving delirium screening using a validated tool upon admission to hospital
- The incidence of delirium in patients (65 and older) acquired over the course of hospital admission

Exclusion Criteria: Palliative patients with comfort care orders.

Why is delirium screening important?

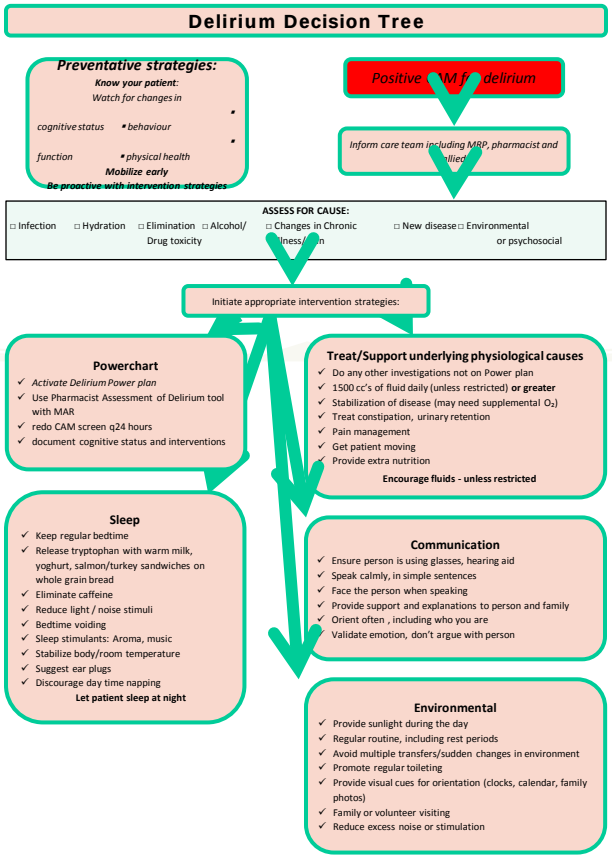
Delirium is associated with negative outcomes such as:

- Increased mortality
- Post-operative complications
- Functional decline
- Long term cognitive impairment

The findings from the study on B2 will inform a delirium strategy for TEGH patients.

Delirium Decision Tree

This algorithm was created with the support of all members of the delirium team based on current best practice guidelines.



Education

WHO?

To ensure success, education had to be provided for all members of the B2 team. The education consisted of in-services outlining:

- What is delirium?
- The seriousness of the diagnosis
- How to use the Confusion Assessment Method (CAM).

WHAT?

The Delirium Team created and introduced a Delirium Decision Tree. The decision tree can assist staff in caring for a patient with delirium and invites proactive interventions to decrease the incidence of delirium.

WHEN?

- The CAM tool is completed on admission to the unit and then every day shift
- Staff are encouraged to completed another CAM if there are changes in the patients condition
- Report the CAM at inter-professional daily minute rounds.

Inter-professional Collaboration

It was recognized early on that in order for this to be a successful endeavor there needed to be a robust representations from all professionals.

The Delirium Team is comprised of a wide range of inter-professional disciplines: Nurses; Hospitalist; Pharmacist; Decision Support; Managers and Informatics personnel.

Hopes for the Future

The information gleaned in this B2 study will help inform how we treat delirium at TEGH

Staff Comments:

'To put strategies in place that will keep the patient safe.'

'Informs my practice. The electronic tool allows me to review if the patient has turned from -ve to +ve or +ve to –ve.'

'If a patient screens positive, the B2 team will review to determine why there is a change in behaviour, for example, infection, medication toxicity. The patient can then be treated appropriately.'

Above all, we care

Acknowledgements: Sarah Bingler; Mariette Stewart; Zelalem Lome; Dr. Christopher Smith; Gloria Seto; Kristine Leggett; Angela Wang; Roxanne Riendeau;.

Strategies at TEGH

Emotional and Behavioural Environment

- Patient centered care, currently working being done on this, patient stories on each unit

Strategies at TEGH

Ethics and Clinical Care

- Advanced care, lots of work already being done

Physical Environment

- Accessibility work being done

TORONTO EAST GENERAL HOSPITAL

Mobility Strategy

Toronto East General Hospital

Overview

1. What is mobility and why is it important?

2. Overview of mobility at TEGH

Bed Rest

- Bed rest is the not always the best form of recovery for sick patients
- Staying in bed can cause elderly patients to lose over a kilogram of muscle mass in 2 days
- This can lead to difficulties with walking and performing daily activities, leading to *functional decline.*

What does the research show?

- Hospitalized older adults who were ambulatory during the 2 weeks prior to admission spent a median of only 43 minutes per day standing or moving (Brown et al., 2009)
- Data from observations conducted in academic hospitals in Toronto found less than 30% of patients were mobilized regularly in hospital (Liu, 2011)

Mobilization

- Mobilization at the hospital simply means being active enough to maintain your functional status while in hospital
- Some patients may sit up on their bed or chair for meals, some may go for walks, and some may perform simple exercises to achieve their mobilization goals in hospital

Mobility at TEGH in Dec 2014

- A team embarked on a journey of performing a current state analysis of mobility at TEGH
- Asked nurses a set of standard questions regarding the mobility of each of the patients they were caring for
- Over 300 survey responses collected

Result Themes:

- Overall sense that mobility was the responsibility of the PT
- Less than half of the patient population surveyed were up for more than 1 meal
- The biggest barriers to more frequent mobilization was patient refusal, pain and cognitive impairment

Mobility at TEGH…How We Got Here

- Following the survey completion it was recognized that TEGH patients in some areas have low levels of mobility
- In order to align with other organizations and to support our Senior Friendly status, the Interprofessional Practice Committee embarked on the creation of a Mobility program for TEGH

Planning in a Nutshell

- Reviewed programs at other organizations
- Formed a working group to map out a program for TEGH
- Validated the program design with content experts
- Identified pilot units and Mobility Champions (A5, H7, MSSU)
- Held a ½ day session for Champions to get feedback and validation on how the program would work on the unit level (RPN, RN, PCA, NPL, Mgr, Sup)

Planning

- Created a patient information pamphlet for education
- Presented the Mobility program as well as the patient pamphlet at 2 separate Patient Experience Panel meetings for feedback and validation
- Mobility Strategy for TEGH is now on the hospital wide Quality Improvement Plan and on the Senior Friendly Strategic Direction

Planning

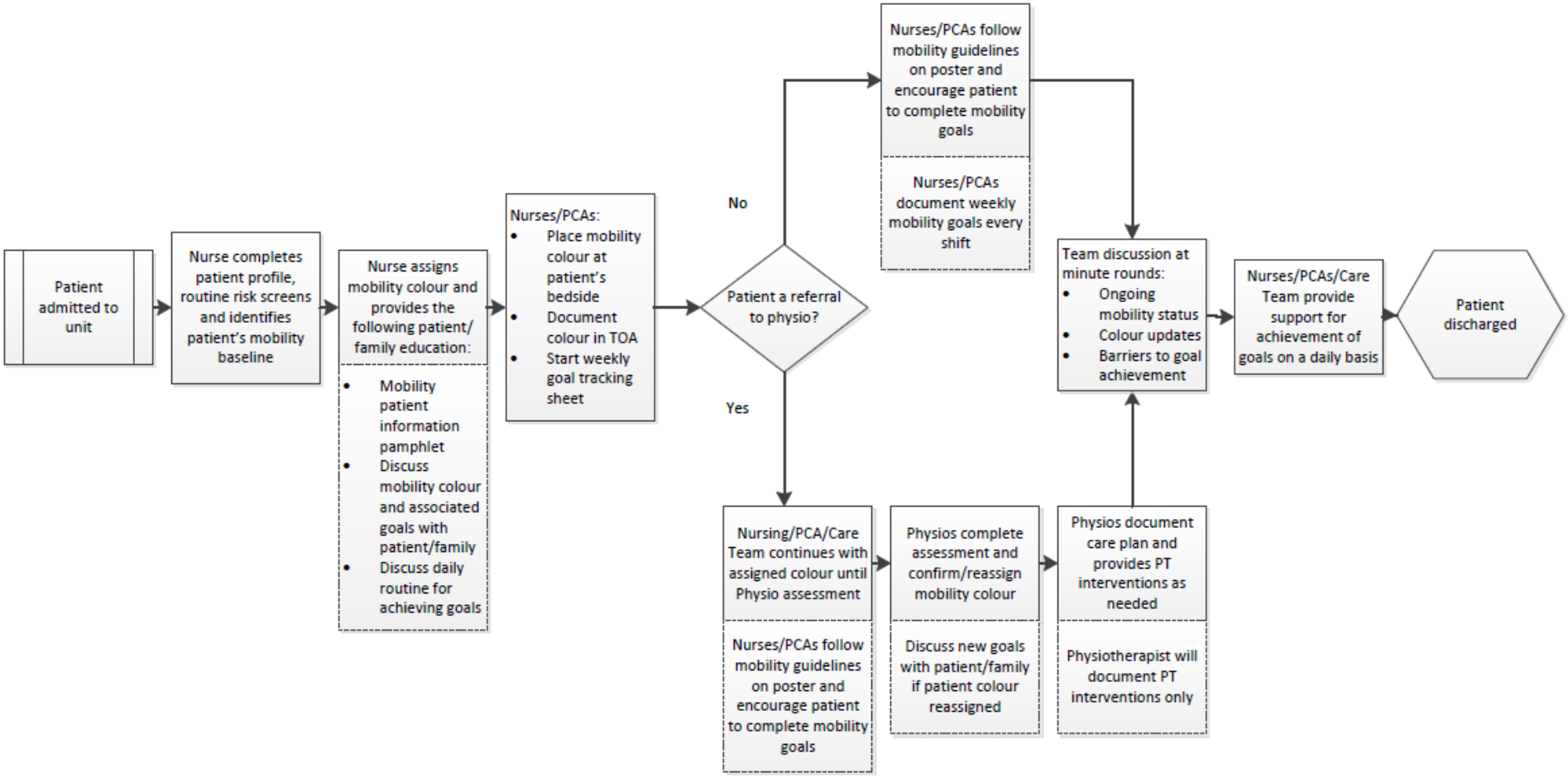
Most importantly:

This strategy shifts mobilization from being a designated task assigned to a single professional group to a shared team responsibility with each team member having complementary roles, including the patient and family!

Process Map

- Created a process map for Mobility from Admission to Discharge and validated this process with Allied Health Teams and the unit Champions

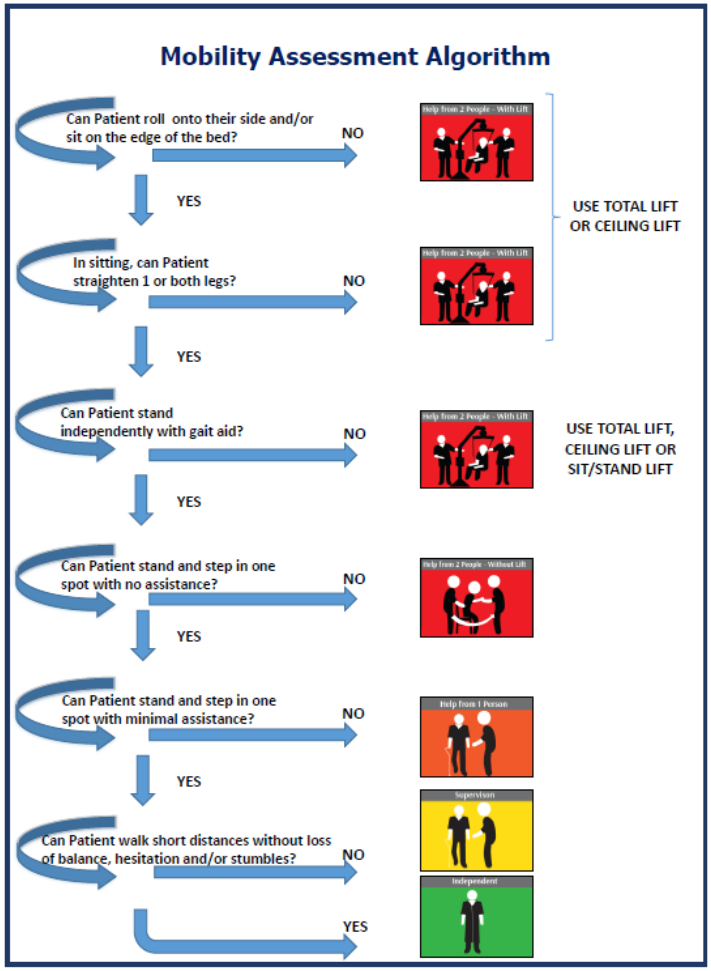
Process Map


Patient admitted to unit
Nurse completes patient profile, routine risk screens and identifies patient's mobility baseline
Nurse assigns mobility colour and provides the following patient/ family education:
• Mobility patient information pamphlet
• Discuss mobility colour and associated goals with patient/family
• Discuss daily routine for achieving goals
Nurses/PCAs:
• Place mobility colour at patient's bedside
• Document colour in TOA
• Start weekly goal tracking sheet
Patient a referral to physio?
No
Nurses/PCAs follow mobility guidelines on poster and encourage patient to complete mobility goals
Nurses/PCAs document weekly mobility goals every shift
Yes
Nursing/PCA/Care Team continues with assigned colour until Physio assessment
Nurses/PCAs follow mobility guidelines on poster and encourage patient to complete mobility goals
Physios complete assessment and confirm/reassign mobility colour
Discuss new goals with patient/family if patient colour reassigned
Physios document care plan and provides PT interventions as needed
Physiotherapist will document PT interventions only
Team discussion at minute rounds:
• Ongoing mobility status
• Colour updates
• Barriers to goal achievement
Nurses/PCAs/Care Team provide support for achievement of goals on a daily basis
Patient discharged

Assigning a Mobility Colour

- On admission, our patients will be assessed for their level of mobility and assigned a colour
- Each colour denotes a certain level of mobility and lists the mobility goals associated with that level

Color assignment decision tree



GOALS FOR YOUR MOBILITY

INDEPENDENT

- Walk around at least 3x/day
- Walk to the washroom for all toileting
- Up in chair for meals
- Manage personal care

SUPERVISION

- Walk around with supervision at least 3x/day
- Walk with supervision to the washroom for all toileting
- Up in chair for meals
- Manage personal care
- Bed exercises 3x/day

1 PERSON ASSIST

- Walk around with assistance at least 1x/day in room or longer distance
- Walk with assistance to wash-room or use commode for all toileting (no bedpans)
- Up with assistance in chair for meals
- Manage personal care
- Bed exercises 3x/day

2 PERSON ASSIST

- Turn/reposition every 2 hours
- If able to sit on a regular chair (i.e. non-tilt wheelchair or gerichair) use commode for all toileting (minimize bedpan use)
- Up with 2 person assistance at least 2x/day in chair
- Manage personal care
- Bed exercises 1x/day

- Turn/reposition every 2 hours
- Collaborative approach to develop appropriate toileting routine
- Up at least 1x/day in appropriate seating (wheelchair or gerichair)
- Manage personal care
- Assisted bed exercises as tolerated

BED REST

MOBILIZATION AND BED EXERCISES MAY BE FACILITATED BY HEALTH TEAM MEMBERS AND/OR FAMILY (WITH APPROPRIATE EDUCATION AND SUPPORT)

Additional Mobilization Tips:

- OT to recommend appropriate seating if patient is unable to tolerate regular chair
- Provide O2 extension tubing to patients who get up to the washroom and require O2 therapy
- Keep needed items within patient's reach (i.e. call bell, water, gait aids)
- Patients who are up in chair should be assessed for need of rest periods and repositioning
- Early identification of patients who may benefit from a room with a ceiling lift
- Reassess need for tubes, lines, drains, etc. daily
- Keep mobility signs up to date

Goals for your **Mobility**

NONE

Help from 1 Person

NAME:

ASK YOUR CARE TEAM IF YOUR FAMILY MEMBERS CAN HELP

YOUR GOALS:

- Walk around with assistance at least 3x/day in room or longer distance
- Walk with help to use the washroom
- Have someone help you into a chair to eat
- Bed exercises at least 3x/day
- Daily Care:
  - Brush your own teeth
  - Change your own clothes
  - Brush your hair

RECOMMENDATION:

Goals for your **Mobility**

Help from 2 People - Without Lift

NAME:

ASK YOUR CARE TEAM IF YOUR FAMILY MEMBERS CAN HELP

YOUR GOALS:

- Turn or shift your body every 2 hours
- Use the commode whenever you can
- Ask two people to help you into a chair twice a day
- Bed exercises at least 3x/day
- Daily Care:
  - Brush your own teeth
  - Change your own clothes
  - Brush your hair

RECOMMENDATION:

Meeting Mobility Goals

- Patients will have a list of mobility goals posted in their room facing their bed so that they can see their mobility goals for the day
- Patients will be required to meet the mobility goals outlined on their colour sheet, with the help of family and TEGH staff if required

Patient Education Pamphlet

- To be given at the time of admission, when the color is assigned
- Color goals will also be reviewed at this time
- Taken to Patient Experience Panel for feedback and changes implemented
- Grade 6 readability level
- Language – English only at this point

Staff Education

- We educated all RNs, RPNs, PSWs, Allied Health and some MDs on the pilot units

- Education was done on the units in a travelling road show style

Education Content

- Current state of patient mobility at TEGH
- Introduction of the mobility initiative at TEGH and the process that got us to this point
- Discuss why is mobility important
- Introduction to the Visual Management Tools
- Tricks and tips for patient education
- Workflow and process map
- Algorithms
- Documentation
- Lift/sling refresher (youtube videos done by our OHS PT)

Documentation

- Documenting in paper at the present time
- All achieved goals documented as they are completed. The information may come from the patient/family if they are independent or from the care team when they assist with goals

Current Metrics

We are measuring 2 metrics during the pilot as we attempt to change the culture:

1. # of patients on the unit with a visual management tool at their bedside
2. # of patients with documented goals

Next Steps

- We are set to roll out to 3 additional units within the next 2 months with a goal of hospital wide implementation by the summer

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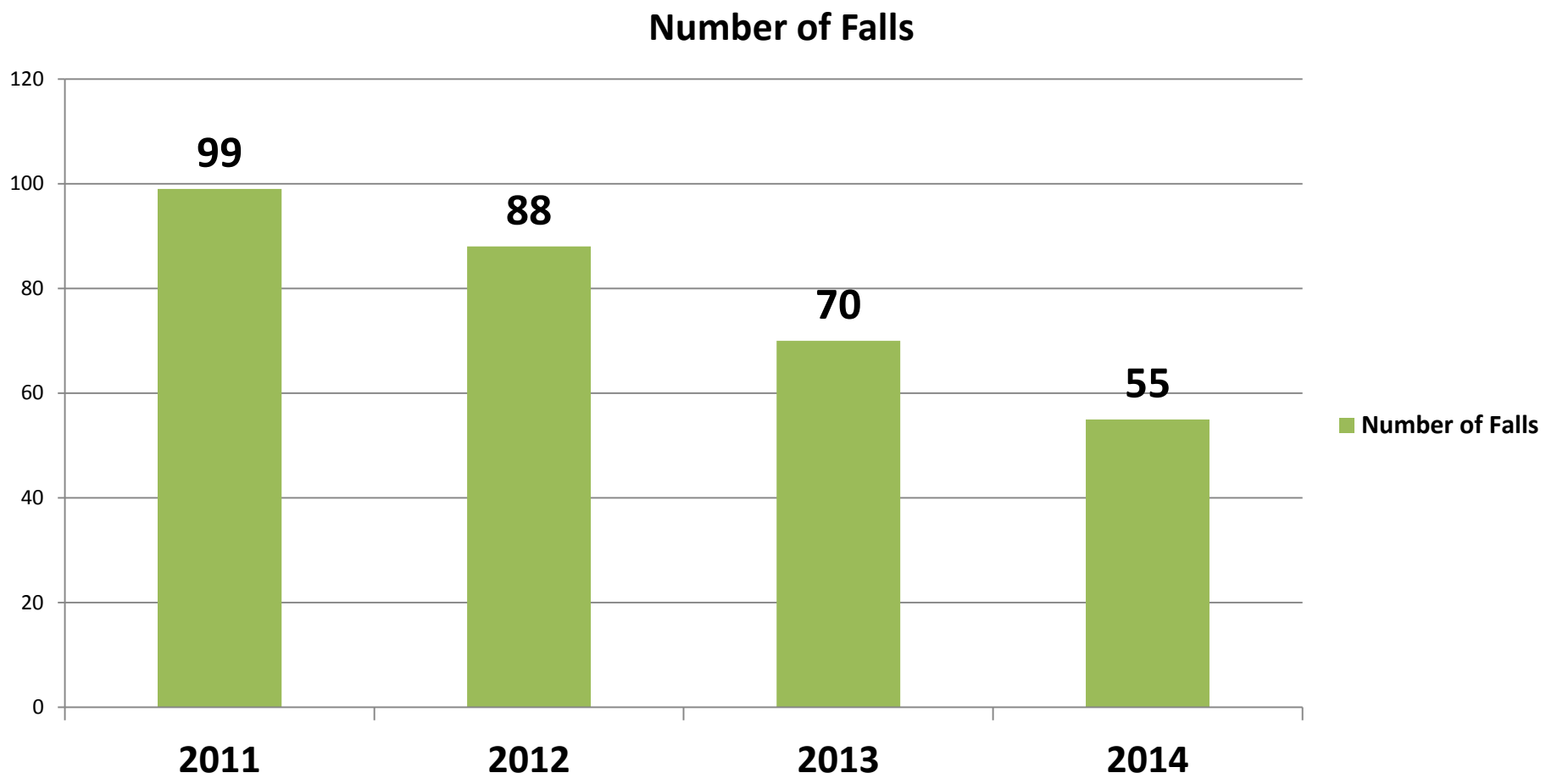
Falls

Toronto East General Hospital

Congratulations IPP Falls Prevention Action Team!



Falls with Harm

Updated: January 2015

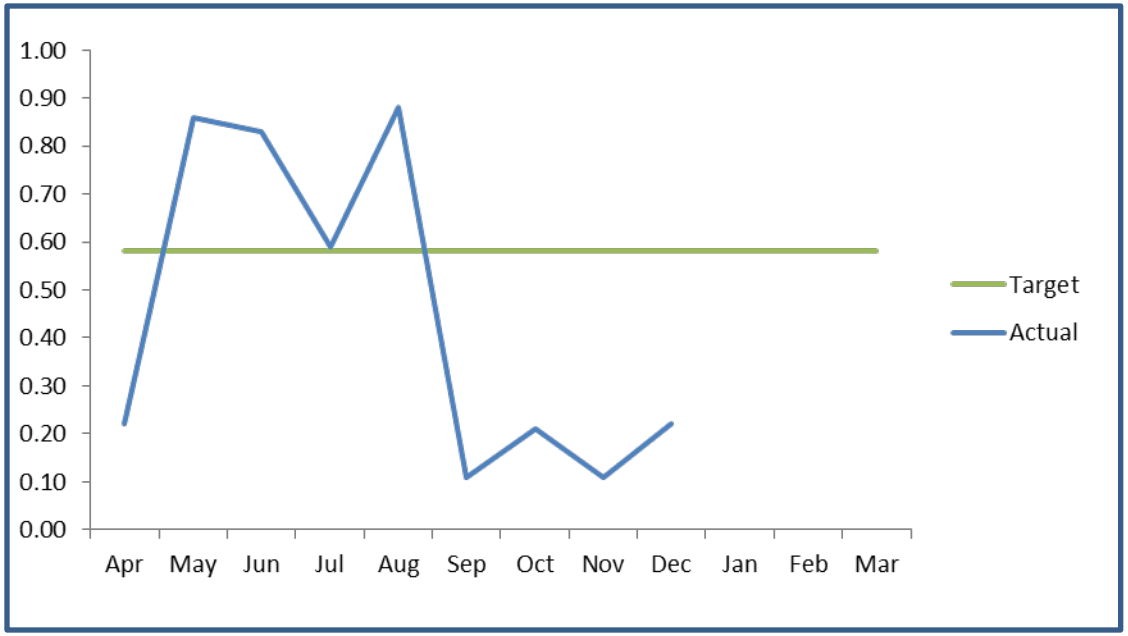
April 2014 – March 2015

TARGET
0.58

0.47

Targeted # of falls w/ harm Monthly	5

November	**0.11**	**1**
December	**0.22**	**2**



Name of Tactic	Target	Current		Next Milestone
% of units who have received new standard work	100%	100%		Follow up on equipment deficiencies complete. Unit champions for ALL units (90%)
% of 1st fallers > 75 with pharmacist medication review	75%	100%		Sample report has been completed. Pharmacists t's have implemented process.
% of patients with mobilization strategy	100%	N/A		Live on H7, B5. MSSU and F3: training to start next week

Key Questions

Key Challenges / Risk ?

Frequent fallers

Do we have the right tactics ?

ED Process this is a ROP for Accreditation

What support do you need from the ops huddle audience?

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Memory Care Unit

Toronto East General Hospital

Memory Care Unit & Collaborative Interdisciplinary Approach

Memory Care Unit

- Create a safe environment for patients that is ‘different’ then a usual busy unit
- Optimise patient’s functionality to facilitate discharge process
- Home if possible or help eligibility to LTC
- Collaborate “ALL HANDS ON DECK”
- On a ‘SHOESTRING’ budget

Inclusion & Exclusion Criteria

Inclusion

- Age 65 or older
- Dementia, Alzheimer's - behavioral disturbances such as agitation, paranoia, aggression, resistance to care, wandering, depression and /or delusions

Exclusion

- Complex high intensity behaviors requiring intense inter-professional clinical assessment, diagnosis, stabilization, and treatment (mental health)
- Emergency or Crisis Admissions

Preparation for Nov 3/14 Opening

- Staff education – P.I.E.C.E.S., GPA, orientation
- Equipment/supply based IPP input
- Secure door
- Surveillance cameras
- Team lead guide

- Interdisciplinary care delivery model/pathway development

Preparation for Nov 3/14 Opening

- Outcome measures
  - Falls, # IPP care plan at huddle, LOS etc.
- Process evaluation SWOT analysis in February 2015
- Tools used to assess and manage responsive behaviour (from behavioural support Ontario)

Staffing Model

Twelve bed unit

Day shift

- 1 RN, 1RPN, 1 PCA – Mon-Friday
- Saturday and Sunday day shift - 2 RPNs, 1 PCA

Evening shift:

- 2 RPNs and 1 PCA

Night shift:

- 1 RPN and 2 PCAs

Staffing Model

Additional unit staff:

SW

PTA

OT

MD

Geriatrician and Psycho-geriatrics – Consultation

Geriatric CNS

Early Success

- IPP (interprofessional staff) taking the lead at Daily Bullet Round
- Patients able to be discharged to community vs. a facility
- LTC Ready sooner as compared to an acute unit
- Families love it!

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Acute Care of the Elderly Unit (A.C.E)

Toronto East General

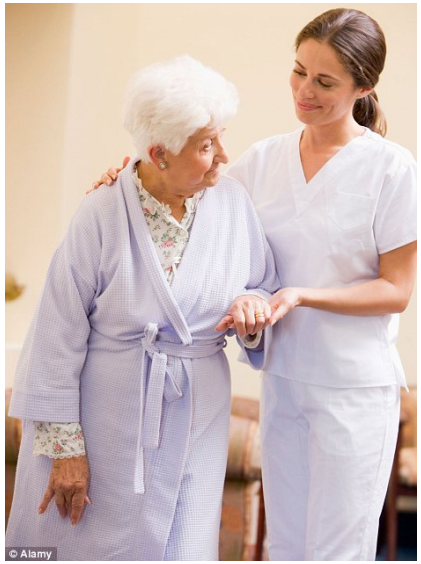
ACE Unit : Acute Care of the Elderly

Change: Needed & Welcome!

- Frail Elderly in ED on the rise
- Long wait times for a bed
- # of elderly living with chronic illnesses
- In ED with acute episodes
- Readmission rates increasing

Research shows! (a few things)

Elderly in hospital:



- Falls
- Medication errors
- Pressure ulcers
- Infections (Palmer et al, 1998)
- Each day in bed = 5% muscle loss (Creditor, 1993)
- When chronic illness treated in a '*disease specific*' model patient likely to have unrelated disease left untreated (Redelmeier et al, 1998)

ACE Improves Care Through…

- A holistic care approach
- A senior friendly environment
- Collaboration with the patient/family
- **Interdisciplinary Team**
- Comprehensive geriatric assessment
- Pharmacology review
- Optimal nursing care
- A focus on function, mobility, independence
- Early discharge planning- aim to return home

Admission Criteria

Admission to ACE

- Age 65 y/o and older
- Via ER/MSSU
- From home or Retirement home
- TEGH catchment area only

Admission Criteria

We DO NOT Admit Patients with:

- Acute stroke
- Active mental health concerns (suicidal ideations, psychosis)
- Advanced dementia
- C.Difficile
- Patients from a Nursing Home

Key Principles

- Comprehensive interprofessional assessment
- Promotion of independence
- Effective communication
  - Family meetings
  - Daily minute rounds
- Education of patient and family
- Patient safety

Key Principles

- Early discharge planning
  - Involving patient/family
  - Collaboration with CCAC on daily basis
  - Use of patient whiteboard EDD
  - Liaise with community supports & GP

ACE Interdisciplinary Core Team

Day	Evening	Night
1RN	1 RN	1 RN
3 RPNs	2 RPNS	1 RPN
2 PCAs	2 PCAs	1 PCA

Dr. Jarred Rosenburg, Geriatrician weekdays. Medicine on-call after hours

SW, OT, PT, PTA, SLP, Rec.Th., Spiritual Care, Volunteers

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