Senior Friendly Hospital

Best Practice for
the Older Adult

Why?

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- Ensure care and service across the organization are delivered in a way that is integrated with the health care system and supports transitions to the community.

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How?

- Launched in 2011 by the province's LHINs and Regional Geriatric Programs
- Environmental scan of 155 hospitals showed what was working and what was not working
- Identified FUNCTIONAL DECLINE as a priority along with delirium and transitions in care.

Functional Decline

- 30-60% of older people experience functional decline when acutely hospitalized
- It is estimated that **up to 50% of older adults** experience functional decline during hospitalization that is largely independent of their presenting medical illness
- One year after hospital discharge, **less than 50% of older adults** recover to their pre-illness level of functioning and rates of long-term care placement are high
- Processes of hospitalization may lead to Functional Decline

*Many factors related to processes across the hospital organization can contribute to functional decline

PROCESS OF CARE-RELATED FACTORS

- Bedrest orders
- Use of physical restraints
- Mobility restricting devices such as indwelling catheters and intravenous lines/poles
- Insufficient nutrition and hydration – extended use of NPO orders, diet not in keeping with patient preferences, inadequate access to water/fluids
- Decreased patient participation in own ADLs
- Polypharmacy, use of medications which can compromise activity/mobility (e.g. sleep medications, psychoactive medications)
- Discharge planning occurs late

EMOTIONAL AND BEHAVIOURAL ENVIRONMENTAL FACTORS

Social deprivation – patient and family/caregiver participation not encouraged or optimized

Insufficient communication and patient engagement during care planning

Discharge planning focused on bed utilization rather than on early determination of patient and family needs

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PHYSICAL ENVIRONMENT FACTORS

Environment does not encourage mobility – e.g. high beds with rails, meals served to patients in bed
Lack of furniture and equipment to support mobility – bedside chairs, mobility aids, handrails/grab bars, commodes and raised toilet seats, seating for showers
Environment contributes to disorientation – lack of clock and calendar in room, lighting does not match time of day, shiny floors that cause glare and can contribute to falls
Noisy environment which disrupts sleep
Sensory deprivation – lack of access to vision and hearing aids

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- *Functional status includes the patient's performance in mobility, basic ADLs (e.g. bathing, dressing, toileting), and Instrumental ADLs (e.g. medication administration, shopping, finances).*

Factors Which Predispose Older Adult Patients to Functional Decline During Hospitalization

* Cognitive impairment
* Lower baseline functional status
* Pre-admission disability in mobility: unsteadiness, use of cane or walker
* Pre-admission disability in Instrumental ADLs (e.g. finances, groceries)
* Delirium
* Depression
* Length of hospital stay

Preventing Functional Decline

* Systemic, inter-professional interventions have demonstrated successful outcomes in the prevention of functional decline during hospitalization
  Physio, OT, Social Worker, PFC, Nursing, Medical, Pharmacy
* Minimize bedrest orders, and consider daily mobility/out-of-bed orders
* Minimize use of physical restraints and of mobility restricting devices such as indwelling catheters and intravenous lines/poles – when used, review daily
* Optimize nutrition and hydration – provide easy access to water and fluids, provide diets consistent with patient preferences, daily review of NPO (no food by mouth) orders
* Obtain Best Possible Medication History (BPMH), reconcile, review and optimize medications to avoid those which may restrict or impair mobility
* Initiate early functional goal setting and discharge planning with patient and family

Preventing Functional Decline (continued)

* Maximize patients' own participation in ADLs while in hospital
* Encourage and assist with regular daily mobility where appropriate; early referral to physiotherapy and occupational therapy for complex patients
* Optimize sleep using non-pharmacologic protocols
* Assess and manage depression
* Assess and treat pain appropriately
* Maximize social engagement – encourage patient and family/caregiver visits and participation with care, volunteer visits
* Initiate early discharge planning focusing on patient and family goals and their needs to return home
* Environmental modifications – floors with a non-glare finish, lighting to match time of day, large clock and calendar in patient rooms for orientation, grab bars where necessary, wide doorways, clutter reduction
* Noise prevention measures – reduced use of overhead pagers, acoustical room treatments, headphones, earplugs
* Furniture and equipment –low beds with rails down, bedside chairs, assistive mobility aids, access to vision and hearing aids, commodes and raised toilet seats, seating in shower

MOST IMPORTANT

Get your patients moving. Up in chair for meals, ambulating to bathroom - no bed pan or urinal.

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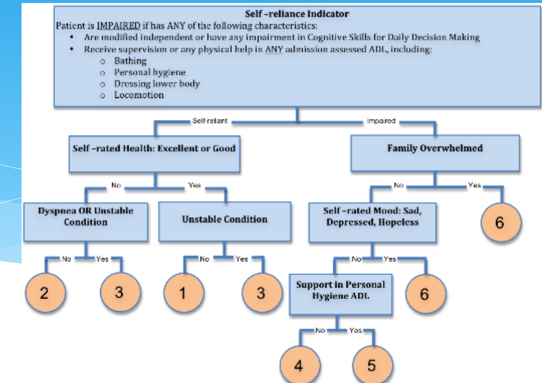
Get PT and OT involved early. Follow their recommendations.

Assess and Restore Philosophy

PURPOSE:

- To extend the functional independence of frail seniors and other people who live in the community for as long as possible;
- To reduce the burden on caregivers by improving psychosocial and health outcomes for frail seniors and other people who live in the community;
- To help LHINs, HSPs and health care professionals adopt evidence-based clinical processes and interventions that are effective in improving the functional independence of community-dwelling seniors and other people.

ASSESS and RESTORE PATHWAY



FRAILTY AND ASSESSMENT MANAGEMENT PATHWAY

- ED Deployment Team case find for patients presenting with warning signs of frailty
  General screening for all patients not recommended

WHEN FRAILTY SUSPECTED/IDENTIFIED THEN

- Assessment Urgency Algorithm (AUA) Screening Tool (quick risk screening tool for adults over 65) done:

  *Identified high scores have further investigations/follow up by the deployment team and A&R Team

  *Identification of ACE appropriate patients, Rehab patients, acute medicine

  *Identification of patients that would benefit from a consult from the BSTU team for a Behavioural Intervention Plan (BIP)

  * Occupational Therapy Assessment completed on high AUA scores

  *Functional Independence Measure (FIM) completion (scores ability to perform ADLs and IADLs)

ASSESS and RESTORE INTERVENTIONS

RECOMMENDATIONS BASED ON ASSESSMENTS

- Develop care plan with interventions including key areas of nutrition, pain, bowel/bladder, cognition/mood, mobility, ADL's, care giver burn out
- Review patient goals of care, values and preferences; *done jointly with patient and family, team if available*
- Review history, current medical conditions
- Medication Review; *input of pharmacy*
- **Reassess care plan at regular intervals;** *set by the team at daily touch points*
- Completion of Lace tool; *done when discharge written by nursing (identifies at risk of readmit)*
- RMR; *completed by nurses 80% of the time, PFC involved with complex patients*
- Discharge family meeting with team; *Nursing, PFC, OT, PT*
- Notify H&CC on day 2 about discharge meetings; attendance when possible

SUPPORT AND REFERRAL

- Home and Community Care
- Discharge Action Plan for patient
- Discharge follow up phone call