Senior Friendly Care in Champlain LHIN Hospitals

Hawkesbury General Hospital

Progress Report 2014: Enhancing Organizational Support through new funding for *Physician - Care of the Elderly* in a rural community

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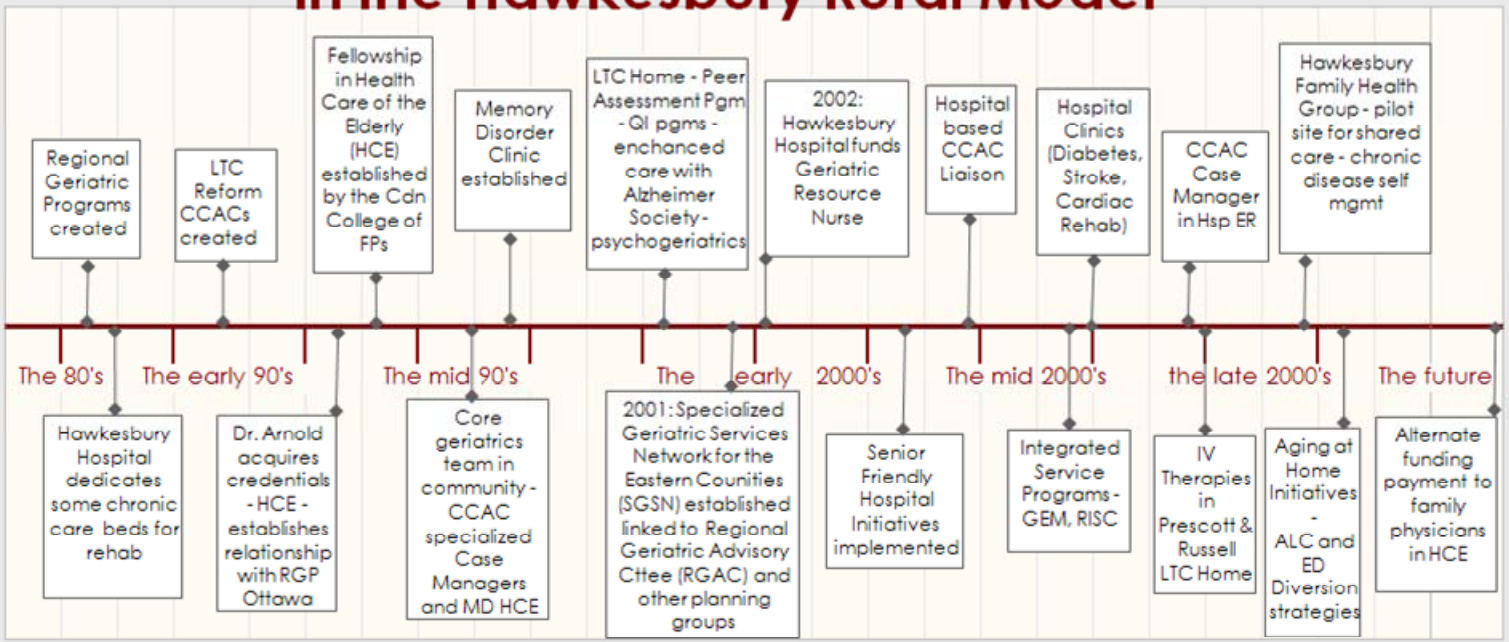
BACKGROUND

- Hawkesbury General Hospital (HGH): rural hospital of 69 beds including 18 CCC
- Specialized Geriatric Services :
  - Geriatric Resource Nurse
  - GEM Nurse
  - Assisted Living Services & affiliated programs such as Stroke, diabetes, OTN
  - Linking with community care and support services
- Senior Friendly Initiative Activities (started 2006):
  - ED Environmental Scan
  - Delirium Protocol
  - Geriatric Nurse member of Hospital Ethics Committee & Elder Abuse Network – Co-Chair of Specialized Geriatric Services Network – Eastern Counties (reporting to Champlain Regional Geriatric Advisory Committee)
  - Prisma Screening with early mobilization, fall and skin sores prevention
- New role of Physician – CoE – November 2013 – contributing to organizational SF support and for processes of care, including transition to community

Milestones in Building Geriatrics Speciality in the Hawkesbury Rural Model



Senior Friendly Initiative

Strengths:

- PHYSICAL
  - ED Environmental Scan
- CARE PROGRAMS
  - Delirium Protocol
  - Mobility Protocol
- ETHICS IN CLINICAL CARE
  - Geriatric Rresource Nurse is member on Ethics Committee with regular Lunch & Learn and member of Elder Abuse Network
  - Decision Tree for Capacity and Elder Abuse Policy
- ORGANIZATIONAL SUPPORT

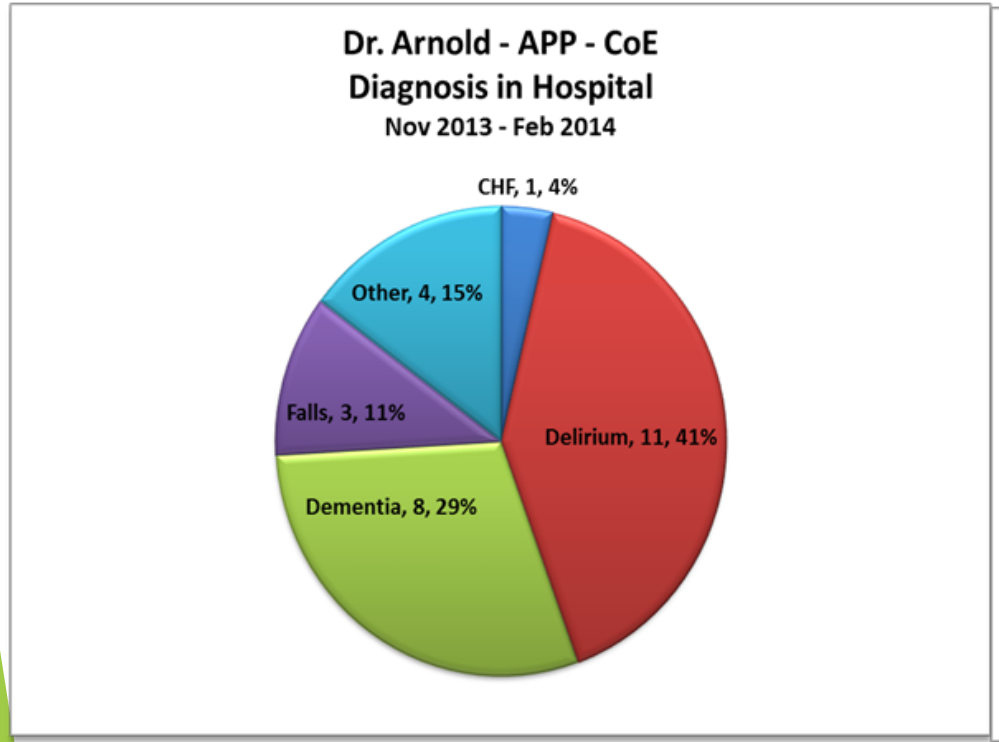
Weaknesses:

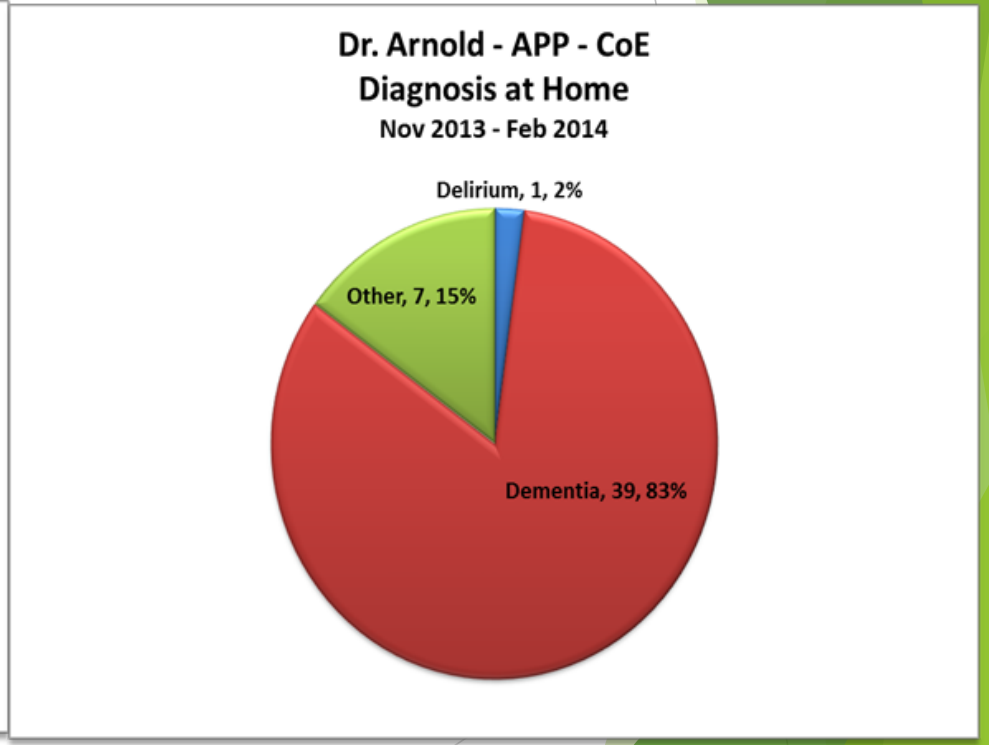
- NO SENIOR FRIENDLY STEERING COMMITTEE
- NO MONITORING
- NO REPORTING TO MAC OR HOSPITAL BOARD
- NO MEDICAL LEADERSHIP / CHAMPION
- LACK OF “BUY-IN” FROM STAFF

APP - Care of the Elderly

20 hrs per week

150-200 new consultations per year-50% hospital & 50% community





CASE STUDY
Acute to Community Care

- 83 yr old female living alone at home, caregiver daughter MH
- Dx of dementia MOCA 22/30, hx of delusions/hallucinations, moderately frail
- On assisted living services – frequent ED visits and admissions
- Admitted in October/November 2013 for N & V, hallucinations, dehydration, pancreatitis
- Main Dx: Acute Renal failure (eGFR 16cc/min) with CRF (eGFR 30 cc/min), dementia, malnutrition, pancreatitis recurrent
- Care plan in community with APP CoE with the help of Assisted Living Coordinator:
  - Visit to family doctor – current practice was visiting ED – last visit to doctor in September 2012 – patient saw family doctor November 14th and q 3months after
  - Referral to nephrology –opinion on renal status – now at GFR 30cc/min
  - Referral to LOFHT pharmacist for medication review
- As of March 2014 (over 5 month period), no visits to ED or admissions to hospital

CASE STUDY
GEM visit to Community Care

- Patient aged 92, widower living alone at home
- ED visit for dizziness and falls
- Seen by GEM Nurse with dx of orthostatic hypotension – diuretic dose adjusted
- 2nd ED visit with persistent sx & daughter caregiver strain so referred to APP CoE
- Home visit within 1 week for geriatric assessment:
  - Sx of prostatism: ditropan with dry mouth and post-void residual 146 cc causing frequency – he was on hytrin with orthostatism
  - On aldactazide with no hx of Heart Failure or hypertension
  - Anemia with high ferritine – family or patient not aware of remote dx of myelodysplasia
- Care plan with de-prescribing and fu with family doctor, urologist and internal medicine with information to patient and family

CASE STUDY
Delirium

- 79 year old widow, living alone at home, no children, independent
- COPD with 2 admissions in last year
- Referral for delirium
- Hospitalized following accidental fall with Fx C1-C2 – collar for 8 weeks
- Evaluation:
  - Painful mouth with sores, hypoK, dehydration, bed sores
- Care Plan:
  - Stop clomipramine 25 mg TID anticholinergic with dry mouth
  - Hold inhaled corticosteroid while glossitis
  - Hydration and lytes correction
  - Bed mattress and wound care
  - Mobilization
- Follow-up at 3 days: patient was happy, eating more, up in chair and walking with assistance

CASE STUDY
End-of-Life Care Planning
represents 10-20% of inpatient consultations

- Patient aged 89 yrs old living in residential facility
- Rheumatoid arthritis on methotrexate, pulmonary fibrosis
- Readmissions following pneumonias with declining function
- GA – immunosuppressed and at end-of-life
- Recommendations: d/c MTX to fight infection and palliative care
- Patient improved and then transferred to LTC home

ACTIVITIES PLANNED FOR 2014

- Establish an HGH Senior Friendly Steering Committee reporting to MAC and Board
- Identify Physician Champion
- Use RGP SFH Toolkit for planning priorities and improvements
- Determine education needs
- Participate in Lunch &Learn Series with Ethics Committee for SF initiatives
- Care Programs:
  - Nutrition protocol
  - Integrated care pathways for CHF & COPD
  - Continuity & transition processes for new Health Link & Medically Complex Patients
- Measurement and dissemination of results