Oversea Corporate Scholarship Program for Clinical Leaders 2016/17

Rehabilitation Nursing in

ST. JOHN'S REHAB in Toronto, Canada

Lo On Yee Jackie, Advanced Practice Nurse

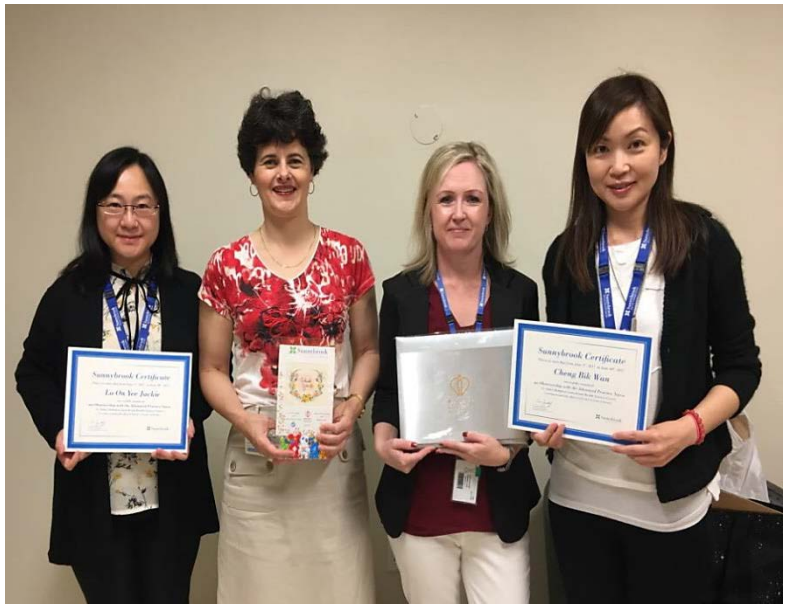
Geriatrics & Rehabilitation, Haven of Hope Hospital

8 May2018

Participant

Group 1
1 – 26 May 2017

Group 2
5 – 30 June 2017



Tse Long Shan
Advanced Practice Nurse
Tuen Mun Hospital

Lo On Yee Jackie
Advanced Practice Nurse
Haven of Hope Hospital

Leung Lok Ming
Advanced Practice Nurse
United Christian Hospital

Cheng Bik Wan
Advanced Practice Nurse
Shatin Hospital

St. John's Rehab (SJR)

at Sunnybrook Health Sciences Centre

SJR Inpatient Wing

SJR Outpatient Wing

- Public funded rehab hospital
- Hospital fee covered by Ontario Health Insurance Plan (OHIP)
- Mission
  - to rebuilt people's life
  - to advance rehabilitation science
- Tailored made rehab programs
  - in-patient
  - out-patient
  - community well clinic
- 4 wards, 40 beds/ward, total 160 beds

Rehab Program

In-patient Rehab Program	Out-patient Rehab Program
Amputee Burn Cardiac Musculoskeletal (orthopedic) Oncology (cancer) Short Term Active Reconditioning (STAR) Stroke and neurological Trauma and complex rehabilitation	Ambulatory Care (variety same as inpatient program) Back on Track Specialty Road to Recovery Workshop Electrical Injury Program
Community Rehab	**Community Wellness Clinics▼**
Active Living Program★ Arthritis Aquatic Program Falls Prevention Program Pre-Hab Program	Acupuncture Clinic Chiropody Clinic Chiropractic Clinic Massage Therapy Clinic

★ fee-for-service care, physician referral required

▼ fee-for-service care, no physician referral required

Environment

Admission Screening System

- Admission screening by SJR bed booking coordinator
- Patient with rehab potential
- Ensure rehab care quality
- Optimum and effective use of resources

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ST. JOHN'S REHAB

Date Referral Received: ☐ am ☐ pm

REHAB ADMISSION INFORMATION FORM

Patient's Last Name: _____ Patient's First Name: _____

Program Requested:
☐ Amputee ☐ Burns ☐ Cardiac ☐ STAR ☐ MSK
☐ Neuro ☐ Oncology ☐ Trauma ☐ Transplant

Diagnosis: _____
Medical Condition: _____

Accommodation Requested: ☐ Ward ☐ Semi ☐ Private ☐ Isolation
Gender: ☐ Male ☐ Female
WSIB patient? ☐ Yes ☐ No ☐ Unconfirmed
Infection Control Issues: _____
Referring Hospital: _____ Contact Name: _____
Phone #: _____ Fax #: _____ Pager #: _____
Date of notification to referring hospital: _____ ☐ am ☐ pm

☐ Application Approved
Date ready for rehab: _____ Date bed offered: _____
Date of admission: _____ Unit / Room / Bed: _____

☐ Application Rejected - Reason for rejection:
☐ Not medically stable
☐ Has no active/measurable/attainable rehab goals
☐ Cannot tolerate at least 30 minutes of therapy
Require
☐ Convalescent Care
☐ LTLD Program

☐ Application Rejected - Reason for rejection:
☐ Not medically stable
☐ Has no active/measurable/attainable rehab goals
☐ Cannot tolerate at least 30 minutes of therapy
☐ Cannot sit unsupported for at least 30 minutes
Require
☐ Convalescent Care
☐ LTLD Program
☐ Long-Term Care
☐ Unable to follow commands/carry over learning --> Require cognitive/behavioural program
☐ More suitable for community based or other rehab program
☐ Cannot accommodate special needs →
☐ IV lines ☐ Tube Feeding ☐ Oxygen
☐ Dialysis ☐ Wandering ☐ Specialized wound care
☐ Psychiatric issues ☐ Other (specify)
☐ Others (specify) _____

Highlight of Observations

Person-Centered Care (PCC)

Interprofessional Collaboration (IPC)

Discharge Planning

Person-Centered Care (PCC)

Patient or Person?

- Deep respect for patients as unique living beings
- Focus on person when provide care to patients

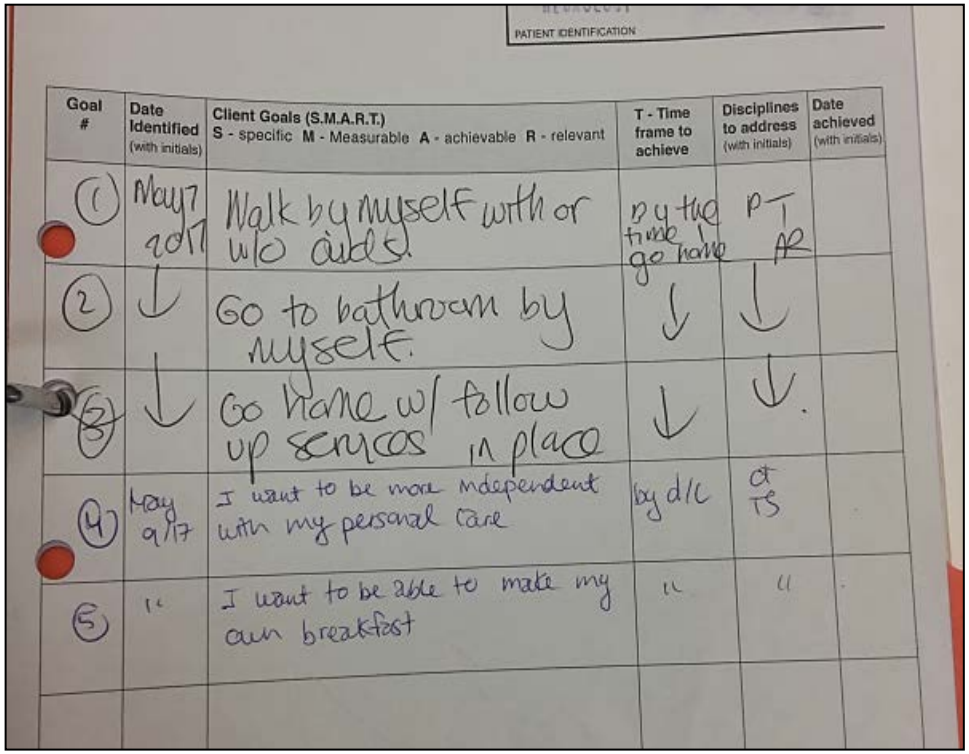
- Better health outcome
  = good patient experience
  = patient goals are met

- Seeking (through engagement) and embedding (through collaboration) the voice of the patient

SJR PCC Framework

Goal Sheet:
My Rehabilitation Goal

- Identify patient concerns ⇨ set goal from patient perspective
- First goal should be set within 2 weeks after admission
- Can be filled by all health care team members
- Discuss and review in rounds
- Monitor patient progress
- Facilitate discharge planning

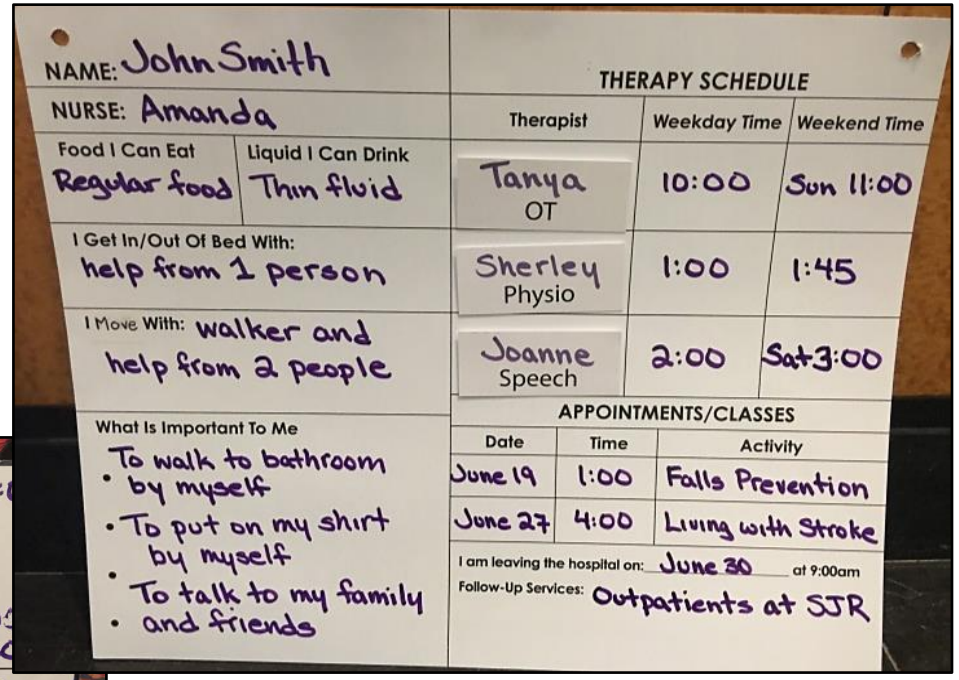


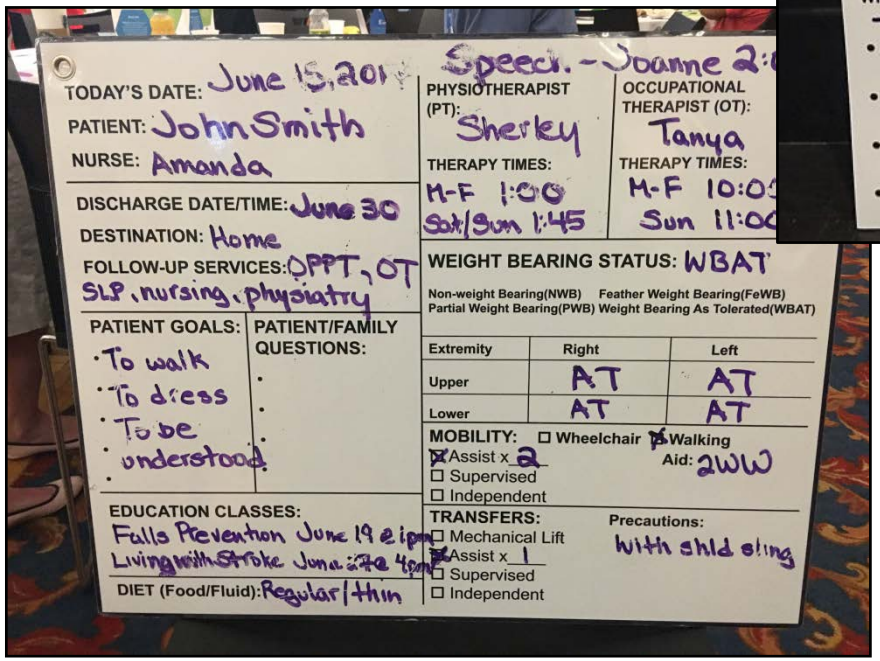
PATIENT IDENTIFICATION

Goal #	Date Identified (with initials)	Client Goals (S.M.A.R.T.) S - specific M - Measurable A - achievable R - relevant	T - Time frame to achieve	Disciplines to address (with initials)	Date achieved (with initials)
1	May 7 2017	Walk by myself with or w/o aids!	By the time go home	PT AR	
2	↓	Go to bathroom by myself.	↓	↓	
3	↓	Go home w/ follow up services in place	↓	↓	
4	May 9/17	I want to be more independent with my personal care	by d/c	OT TS	
5	"	I want to be able to make my own breakfast	"	"	

Engagement Whiteboard

- Jargon free
- At bedside
- Enhance communication
- Update on daily basis if indicated

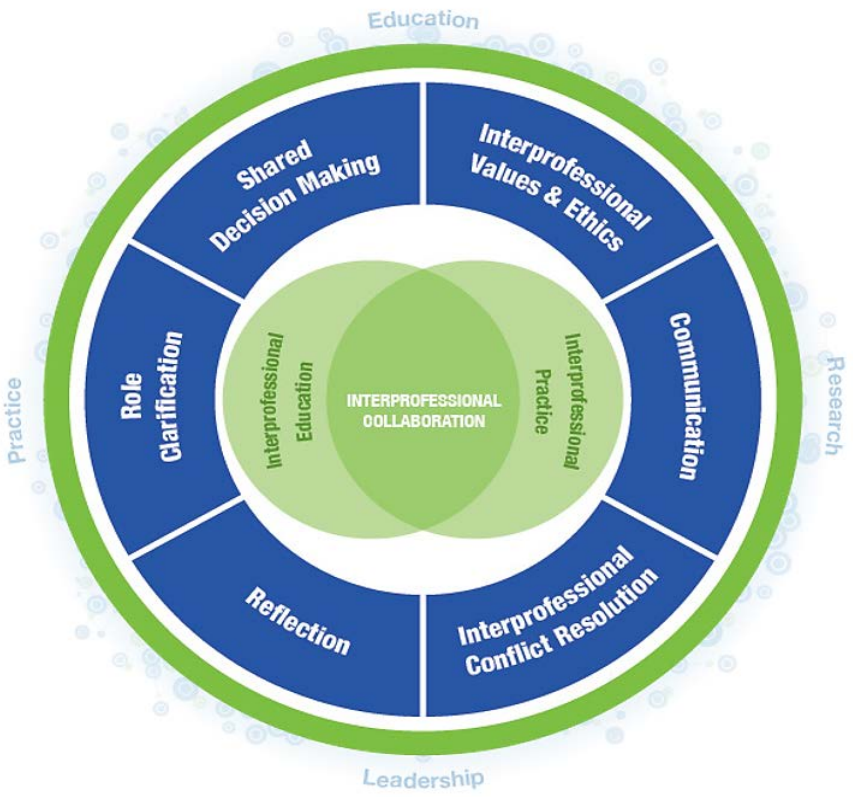




Proposed new version at 2017 Sunnybrook IPC Showcase

Interprofessional Collaboration (IPC)

- Health care delivery model in SJR
- Emphasize on working together across different roles to improve patient health outcomes
- Full team collaboration in all aspects of patient care
- Non-hierarchical decision-making
- Promote relationships among patients, their families and the health professionals
- IPC framework
  - IP Practice
  - IP Education



SJR IPC Framework

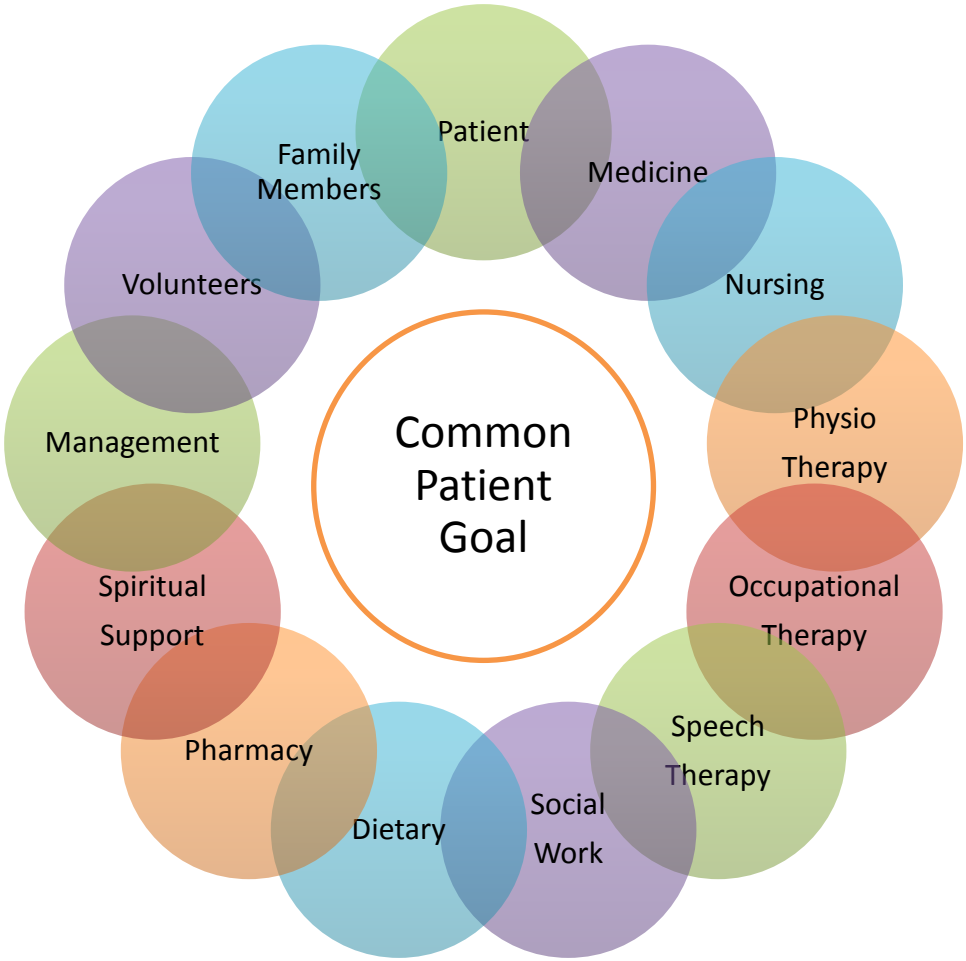
IP Practice

IP Team

- Working together to deliver the highest quality of care
- Disciplines have a common patient goal

IP Huddles

- Fall huddle, for example
  - every new patient
  - patient who had fall or near miss incident



IP Team Members

IPC Education

- Learning about, from and with each other disciplines

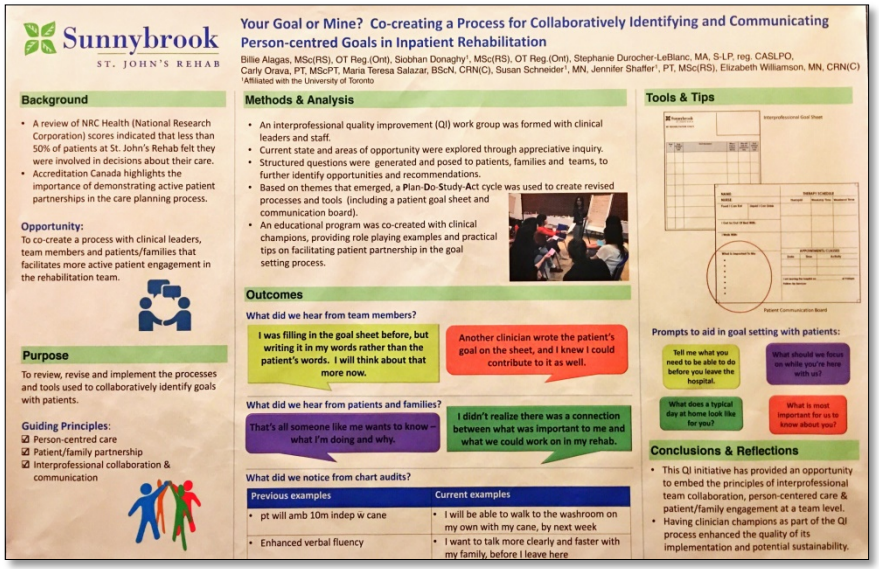
IP Orientation

- All new staff
- Best practice, health and safety matters e.g. fall prevention, documentation
- Ensure same language and same standard

Sunnybrook IPC Showcase

- Annual event for the excellence in team learning and collaboration care
- Feature keynote, collaborative learning activities and poster presentation

2017 Sunnybrook IPC Showcase



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ST. JOHN'S REHAB

Your Goal or Mine? Co-creating a Process for Collaboratively Identifying and Communicating Person-centred Goals in Inpatient Rehabilitation

Billie Alagas, MSc(RS), OT Reg.(Ont), Siobhan Donaghy[1], MSc(RS), OT Reg.(Ont), Stephanie Durocher-LeBlanc, MA, S-LP, reg. CASLPO, Carly Orava, PT, MScPT, Maria Teresa Salazar, BScN, CRN(C), Susan Schneider[1], MN, Jennifer Shaffer[1], PT, MSc(RS), Elizabeth Williamson, MN, CRN(C)
[1]Affiliated with the University of Toronto

Background

- A review of NRC Health (National Research Corporation) scores indicated that less than 50% of patients at St. John's Rehab felt they were involved in decisions about their care.
- Accreditation Canada highlights the importance of demonstrating active patient partnerships in the care planning process.

Opportunity:
To co-create a process with clinical leaders, team members and patients/families that facilitates more active patient engagement in the rehabilitation team.

Purpose
To review, revise and implement the processes and tools used to collaboratively identify goals with patients.

Guiding Principles:
- ☑ Person-centred care
- ☑ Patient/family partnership
- ☑ Interprofessional collaboration & communication

Methods & Analysis

- An interprofessional quality improvement (QI) work group was formed with clinical leaders and staff.
- Current state and areas of opportunity were explored through appreciative inquiry.
- Structured questions were generated and posed to patients, families and teams, to further identify opportunities and recommendations.
- Based on themes that emerged, a Plan-Do-Study-Act cycle was used to create revised processes and tools (including a patient goal sheet and communication board).
- An educational program was co-created with clinical champions, providing role playing examples and practical tips on facilitating patient partnership in the goal setting process.

Outcomes

What did we hear from team members?

I was filling in the goal sheet before, but writing it in my words rather than the patient's words. I will think about that more now.

Another clinician wrote the patient's goal on the sheet, and I knew I could contribute to it as well.

What did we hear from patients and families?

That's all someone like me wants to know – what I'm doing and why.

I didn't realize there was a connection between what was important to me and what we could work on in my rehab.

What did we notice from chart audits?

Previous examples	Current examples
• pt will amb 10m indep w cane	• I will be able to walk to the washroom on my own with my cane, by next week
• Enhanced verbal fluency	• I want to talk more clearly and faster with my family, before I leave here

Tools & Tips

Prompts to aid in goal setting with patients:

- Tell me what you need to be able to do before you leave the hospital.
- What should we focus on while you're here with us?
- What does a typical day at home look like for you?
- What is most important for us to know about you?

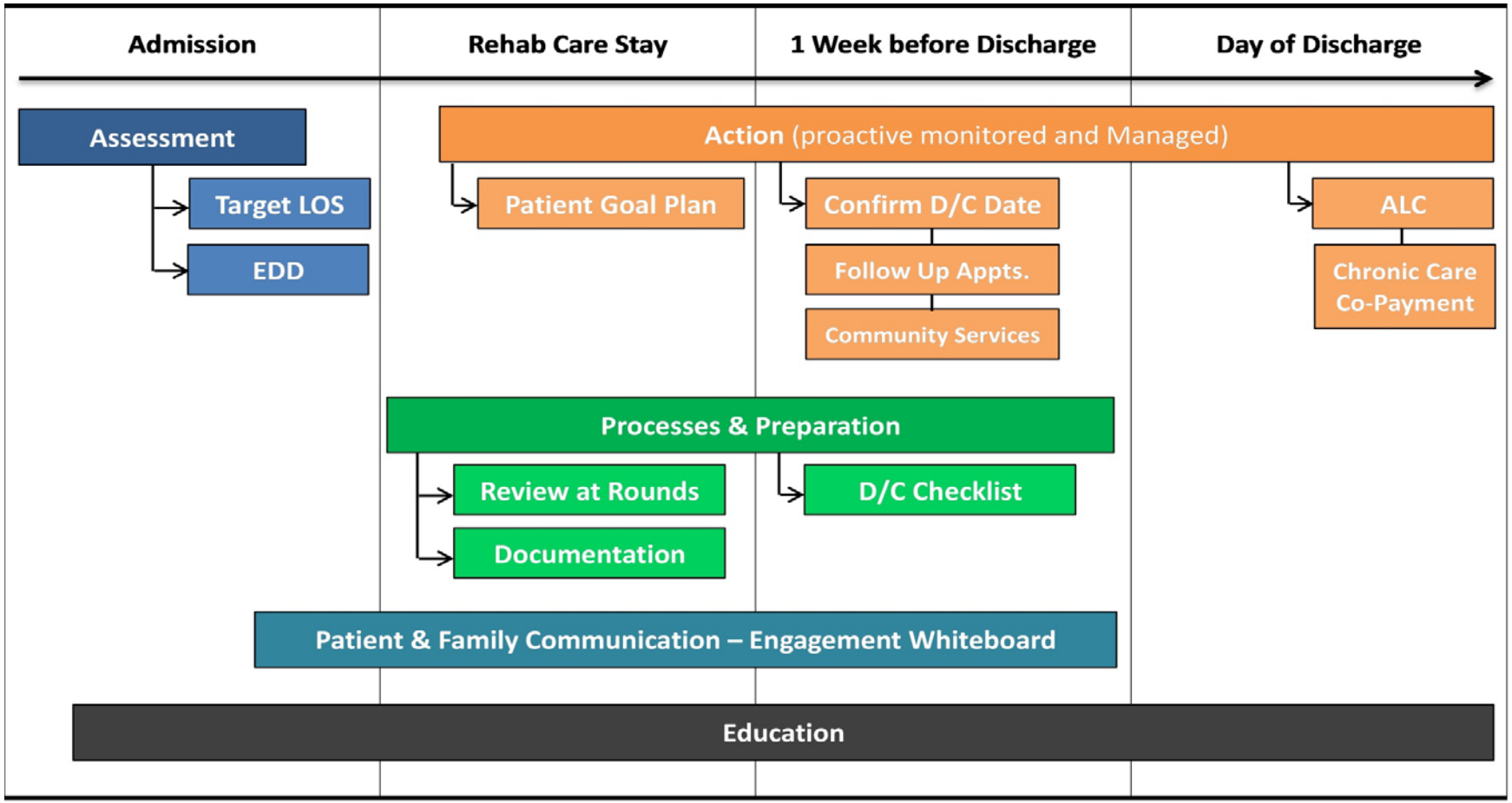
Conclusions & Reflections

- This QI initiative has provided an opportunity to embed the principles of interprofessional team collaboration, person-centered care & patient/family engagement at a team level.
- Having clinician champions as part of the QI process enhanced the quality of its implementation and potential sustainability.

2017 SJR Poster Presentation at IPC Showcase

Discharge Planning

- A proactive multi-faceted IP process that begins at admission



LOS Length of Stay **EDD** Expected D/C Date **D/C** Discharge **ALC** Alternate Level of Care

Discharge Planning Strategies

- Discharge policy
- Target Length of Stay (LOS)
- Expected Discharge Date (EDD)
- Standardized discharge best practice
  - Four standardized questions in daily care planning rounds
  - IP Discharge checklist
  - Patient and family communication
    - Discharge pamphlet
    - Bedside poster "Helping You Get Home"
    - Engagement Whiteboard
    - Discharge Notice
- Escalation of complex discharge cases
  - Discharge planning flow map
  - Alternate Level of Care (ALC)

Discharge Planning Strategies

Target Length of Stay (LOS)

- Pre-set by the organization
- Diagnosis-based

Diagnosis	Target LOS (days)
TKR/THR	10
Fracture Hip	32
Fracture Femur	42
Cardiac Rehab	14
Pneumonia	19
Mild Stroke	8.3
Moderate Stroke	15.5-27.9

Expected Discharge Date (EDD)

- Based on patient goals and rehab outcomes
- With reference to Target LOS
- Draft EDD is set one week after admission or after IP team completed their assessment
- EDD will be reviewed and confirmed in weekly IP team meeting
- Patient / Substituted Decision Maker / families are informed once EDD set

Discharge Planning Strategies

Four Standardized Questions

Standard Questions for Daily Care Planning Rounds

1. What is the EDD, are the patient/SDM aware?
2. What is important to the patient/family to prepare for discharge?
3. What actions are required to progress the discharge?
4. Who will speak to the patient/family on update information regarding discharge plan and update patient whiteboard?

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IP Discharge Checklist

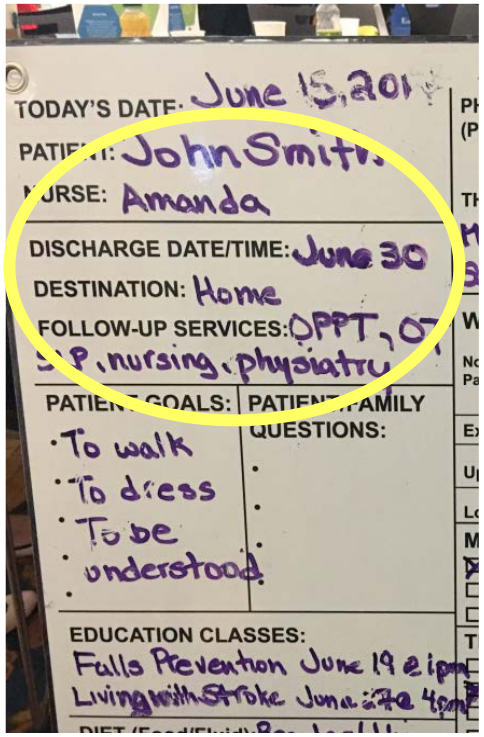
Accountability	Not applicable (initial)	Discipline Responsible	Date completed (MMM/DD)	Signature
1. Discharge family team meeting		TC		
2. Transportation identified and arranged for discharge		OT / PT		
3. Arranged / Referrals completed and submitted (please check): □ CCAC □ Home Oxygen Program □ Outpatient Services □ Other community services / resources _____		TC		
4. Ontario Disability Support Program funding form completed (diet / feedings)		RD		
5. Nutritional education provided Nutritional transfer notes sent		RD		
6. Follow-up appointments info provided		PA		
7. Drug coverage needs addressed □ **Pharmacy** to supply information on drug coverage data □**Physician** to write LU codes on discharge prescription		MD/ Pharmacy		
8. Medication reconciliation upon discharge completed		Pharmacy		
9. Warfarin / INR record faxed (copy provided to **next provider of care)** □ **Pharmacy** ensures form is complete / **PA** faxes		PA / Pharmacy		
10. Medication Side Effects provided to patient □ **Pharmacy** provides In-Patient Teaching Medication schedule □ **Nurse** teaches patient regarding side effects		Pharmacy / NSG		
11. Discharge prescription ordered and faxed as requested		PA / TC		
12. GOALS achieved and reviewed with the patient a. Goal sheet provided to patient on discharge		TC / NSG		
13. Discharge order written		MD / TC		
14. Discharge Notification given to patient		MD / TC		
15. Discharge instructions / package prepared / given		TC / NSG		
16. Equipment recommendations provided		OT / PT		
17. Appointments arranged for discharge / outpatient		TC / NSG		
18. Previous evening – scripts reviewed & in chart		TC / NSG		
19. Script given to patient and reviewed with patient day of discharge		TC / NSG		
20. CCAC wound care supplies provided		TC/ NSG		
21. FINAL CHECK of "CHECK LIST"		**TC / NSG**		

Discharge Planning Strategies
Patient and Family Communication

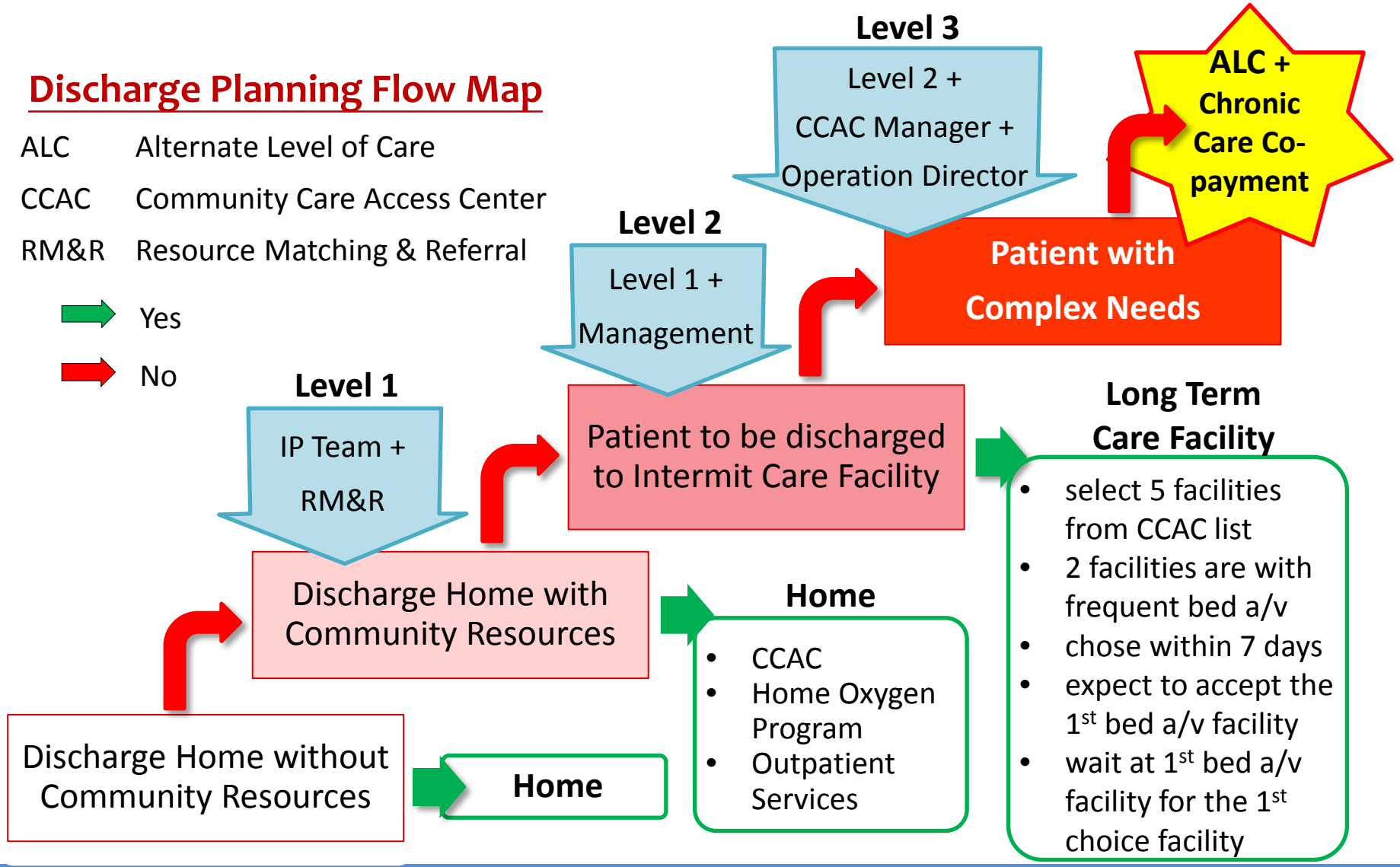
Discharge Pamphlet

Bedside Poster

Engagement Whiteboard



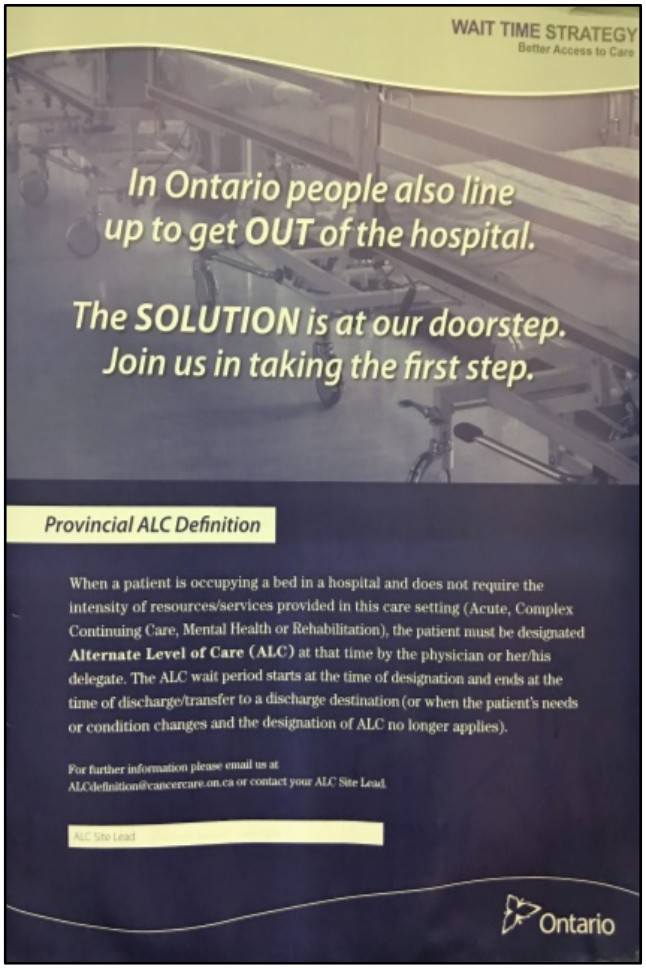
Discharge Planning Strategies
Escalation of Complex Discharge Cases



Discharge Planning Strategies
Escalation of Complex Discharge Cases

Alternate Level of Care (ALC)

- State supported policy
- Patient who occupying a bed in a hospital and do not require the services provided in this care setting
- Administrative Review
  - by Operation Director and CCAC Manager to determine if conditions are met for assessing a per diem charge
- Official letter
- Chronic Care Co-Payment
  - hospital fee that is not covered by OHIP
  - patient has to pay extra fee
- Ensure appropriate use of resources



Ontario ALC


many
Thanks!