

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 May 2018



醫院管理局
HOSPITAL
AUTHORITY



基督教靈實協會
靈實醫院
HAVEN OF HOPE
CHRISTIAN SERVICE
HAVEN
OF HOPE
HOSPITAL



Participant



Group 1
1 – 26 May 2017

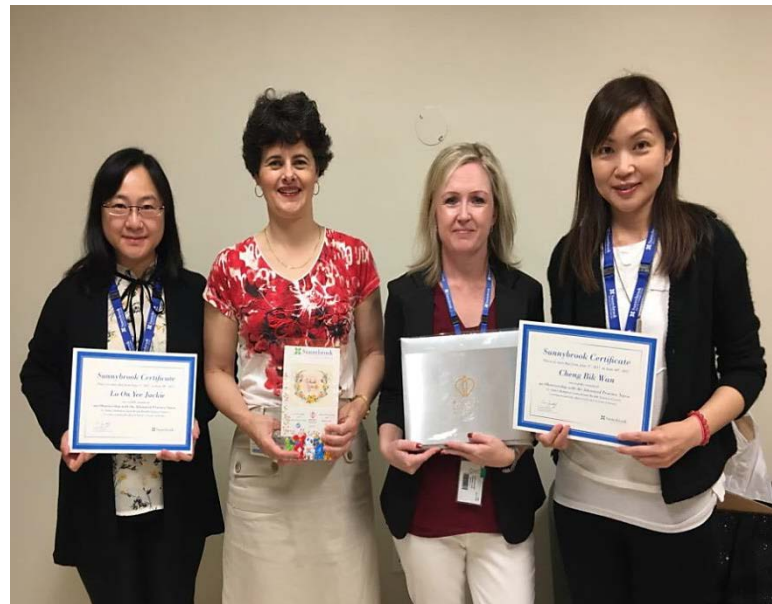


Tse Long Shan
Advanced Practice Nurse
Tuen Mun Hospital

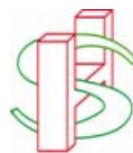


Leung Lok Ming
Advanced Practice Nurse
United Christian Hospital

Group 2
5 – 30 June 2017



Lo On Yee Jackie
Advanced Practice Nurse
Haven of Hope 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
<p>Amputee</p> <p>Burn</p> <p>Cardiac</p> <p>Musculoskeletal (orthopedic)</p> <p>Oncology (cancer)</p> <p>Short Term Active Reconditioning (STAR)</p> <p>Stroke and neurological</p> <p>Trauma and complex rehabilitation</p>	<p>Ambulatory Care (variety same as inpatient program)</p> <p>Back on Track Specialty</p> <p>Road to Recovery Workshop</p> <p>Electrical Injury Program</p>
Community Rehab	Community Wellness Clinics▼
<p>Active Living Program★</p> <p>Arthritis Aquatic Program</p> <p>Falls Prevention Program</p> <p>Pre-Hab Program</p>	<p>Acupuncture Clinic</p> <p>Chiropody Clinic</p> <p>Chiropractic Clinic</p> <p>Massage Therapy Clinic</p>

★ fee-for-service care, physician referral required

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



Environment



Rehabilitation Nursing in St. John Rehab in Toronto, Canada



Admission Screening System



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

 **Sunnybrook**
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

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

☐ Cannot sit unsupported for at least 30 minutes

☐ Unable to follow commands/carry over learning --> Require cognitive/behavioural program

☐ More suitable for community based or other rehab program

☐ Cannot accommodate special needs →

☐ Others (specify) _____

☐ IV lines

☐ Tube Feeding

☐ Oxygen

☐ Dialysis

☐ Wandering

☐ Specialized wound care

☐ Psychiatric issues

☐ Other (specify) _____

Require

☐ Convalescent Care

☐ LTLD Program

☐ Long-Term Care

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

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

TODAY'S DATE: June 15, 2017

PATIENT: John Smith

NURSE: Amanda

DISCHARGE DATE/TIME: June 30

DESTINATION: Home

FOLLOW-UP SERVICES: OPPT, OT, SLP, nursing, physiatry

PATIENT GOALS:

- To walk
- To dress
- To be understood

PATIENT/FAMILY QUESTIONS:

EDUCATION CLASSES:

Falls Prevention June 19 @ 1pm

Living with Stroke June 27 @ 4pm

DIET (Food/Fluid): Regular/Thin

PHYSIOTHERAPIST (PT): Sherley

THERAPY TIMES:

M-F 1:00

Sat/Sun 1:45

OCCUPATIONAL THERAPIST (OT): Tanya

THERAPY TIMES:

M-F 10:00

Sun 11:00

WEIGHT BEARING STATUS: WBAT

Non-weight Bearing(NWB) Feather Weight Bearing(FeWB)

Partial Weight Bearing(PWB) Weight Bearing As Tolerated(WBAT)

Extremity	Right	Left
Upper	AT	AT
Lower	AT	AT

MOBILITY: ☐ Wheelchair ☒ Walking

☒ Assist x 2 ☐ Supervised ☐ Independent

Aid: 2WW

TRANSFERS: ☐ Mechanical Lift ☒ Assist x 1 ☐ Supervised ☐ Independent

Precautions: with shd sling

NAME: John Smith

NURSE: Amanda

Food I Can Eat: Regular food

Liquid I Can Drink: Thin fluid

I Get In/Out Of Bed With: help from 1 person

I Move With: walker and help from 2 people

What Is Important To Me

- To walk to bathroom by myself
- To put on my shirt by myself
- To talk to my family and friends

THERAPY SCHEDULE

Therapist	Weekday Time	Weekend Time
Tanya OT	10:00	Sun 11:00
Sherley Physio	1:00	1:45
Joanne Speech	2:00	Sat 3:00

APPOINTMENTS/CLASSES

Date	Time	Activity
June 19	1:00	Falls Prevention
June 27	4:00	Living with Stroke

I am leaving the hospital on: June 30 **at** 9:00am

Follow-Up Services: Outpatients at SJR



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

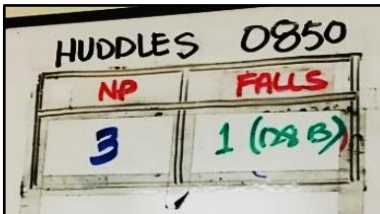


IP Team

- **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

Sunnybrook
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, MSc(RS), OT Reg (Ont), Stephanie Durocher-Lefebvre, MA, S-LP, reg, CASLPO, Carly Orava, PT, MScPT, Maria Teresa Salazar, BScN, CRNCC, Susan Schneider, MN, Jennifer Shaffer, PT, MSc(RS), Elizabeth Williamson, MN, CRNCC
*Affiliated with the University of Toronto

Background

- A review of NRC (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

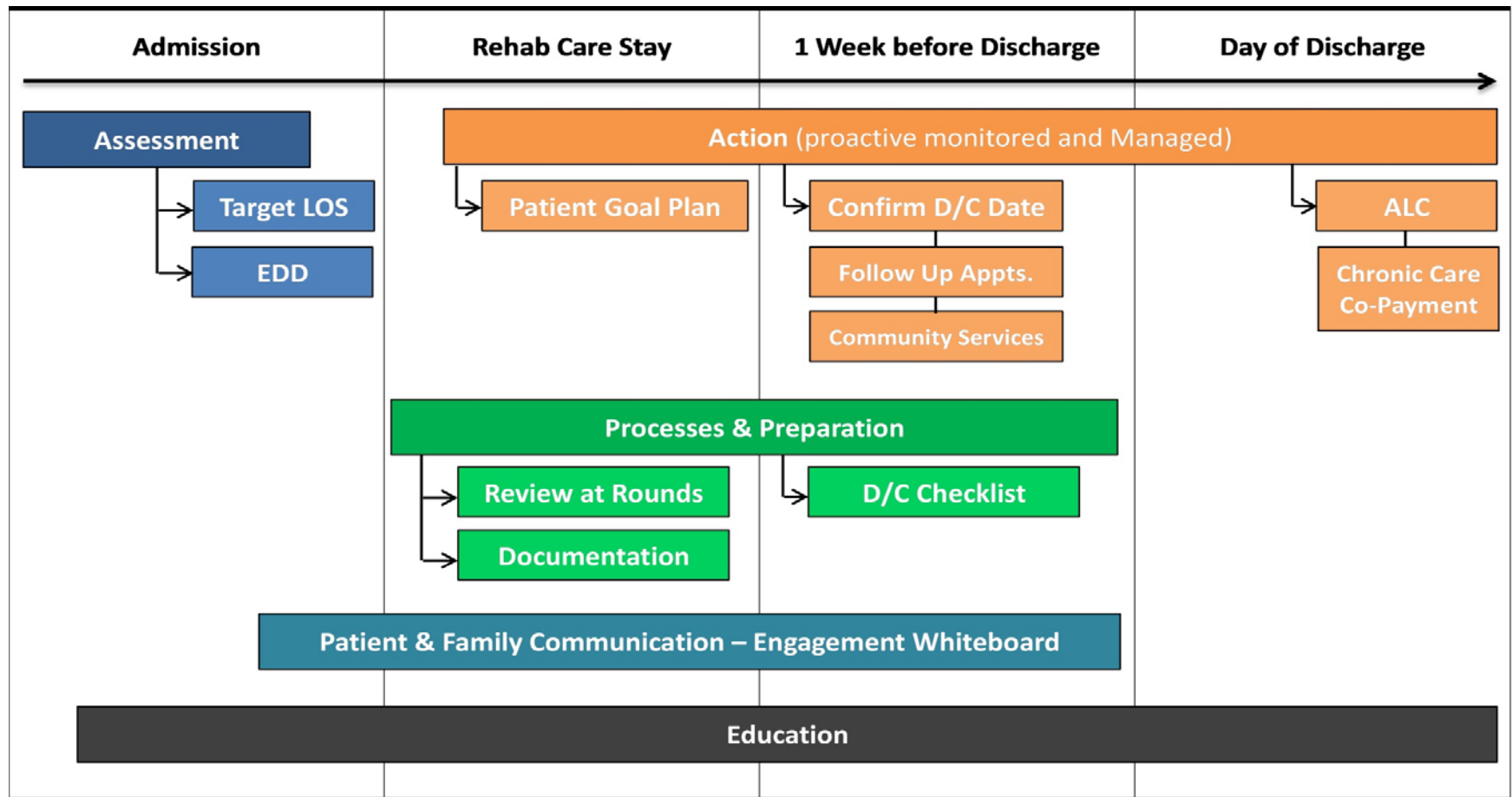
- This QI initiative has provided an opportunity to embed the principles of interprofessional team collaboration, person-centred care & patient/family engagement at a team level.
- Having clinician champions as part of the QI process enhanced the quality of its implementation and potential sustainability.

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?



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): <input type="checkbox"/> CCAC <input type="checkbox"/> Home Oxygen Program <input type="checkbox"/> Outpatient Services <input type="checkbox"/> 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 <input type="checkbox"/> Pharmacy to supply information on drug coverage data <input type="checkbox"/> 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) <input type="checkbox"/> Pharmacy ensures form is complete / PA faxes		PA / Pharmacy		
10. Medication Side Effects provided to patient <input type="checkbox"/> Pharmacy provides In-Patient Teaching Medication schedule <input type="checkbox"/> 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



For more information, please speak with a member of your healthcare team.

If you're a loved one in a General Medicine unit, such as B4, C4 or D4, you may speak with the Transitional Coordinator. The Transitional Coordinator is a health care professional that will help facilitate your care from admission to discharge, with the goal of providing a seamless transition for you back to the community.

Bayview Campus
2075 Bayview Avenue
Toronto, Ontario M2H 3B4
Telephone: 416-480-6100

Holland Centre
Holland Orthopaedic & Arthritis Centre
43 Wellesley Street East
Toronto, Ontario M4T 1G1
Telephone: 416-967-8600

St. John's Rehab
385 Cummer Avenue
Toronto, Ontario M5M 3G4
Telephone: 416-226-6700

www.sunnybrook.ca

Fully affiliated with the University of Toronto



There's no place like home: Doug's Story

Doug, an 87-year-old, recently suffered a serious fall and broke several vertebrae in his spine. From the moment he was admitted to Sunnybrook, his healthcare team began to work with Doug and his family to plan for his discharge back to the comfort of his home.

Doug spent two weeks at Sunnybrook. Throughout his stay, nurses, doctors, social workers, physiotherapists and Transitional Coordinators worked with Doug and his family to determine what support he and his family would need to assist them with his transition back home. As a result of the planning and conversations, it was no surprise that once Doug no longer needed the acute care services of the hospital, he would head back home to continue his recovery.

Doug's healthcare team identified a detailed care plan based on his assessed care needs and helped arrange for the required services to be provided at Doug's home, where he lives alone. His care plan included support from family and friends for various tasks around the house and coordinating other services within his home.

Since returning home Doug has made steady progress in regaining his mobility and independence. Ten days after discharge he said, "I'm managing quite well in my home with the assistance I'm getting. In fact, I now only require one little promise to get me through the entire day. I feel safe and confident with the support I'm getting and am happy with the pace of my recovery."



There really is no place like home.

Especially when you or a loved one have been sick or injured and are in the hospital.

Your Sunnybrook healthcare team will help you:

- Understand what brought you to the hospital
- Begin a treatment plan
- Create a supportive plan where you will continue your recovery at home

We will work with you, and your family, on your transition back home.



Bedside Poster

Helping You Get Home

Ask yourself:

- 1 What do I need to do to manage my health at home?



- 2 Who will help care for my health at home?



- 3 Patients leave the hospital at 11 a.m. How will I get home?



- 4 Do I know how and when to take my medications?



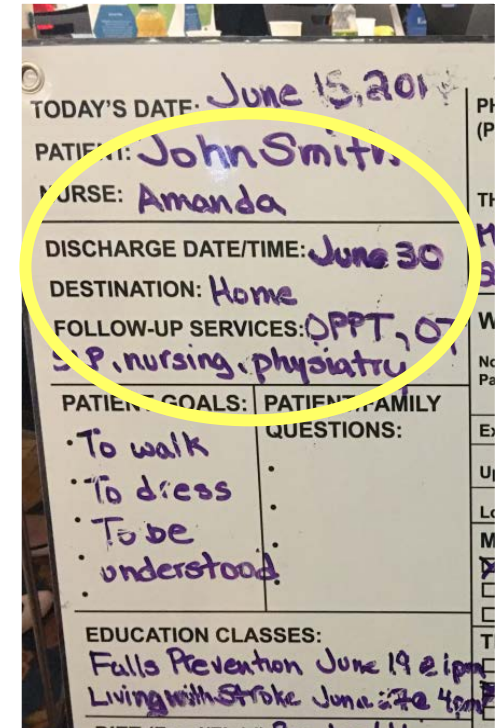
- 5 When should I call my family doctor?



Talk to your care team today.



Engagement Whiteboard





Discharge Planning Strategies

Escalation of Complex Discharge Cases



Discharge Planning Flow Map

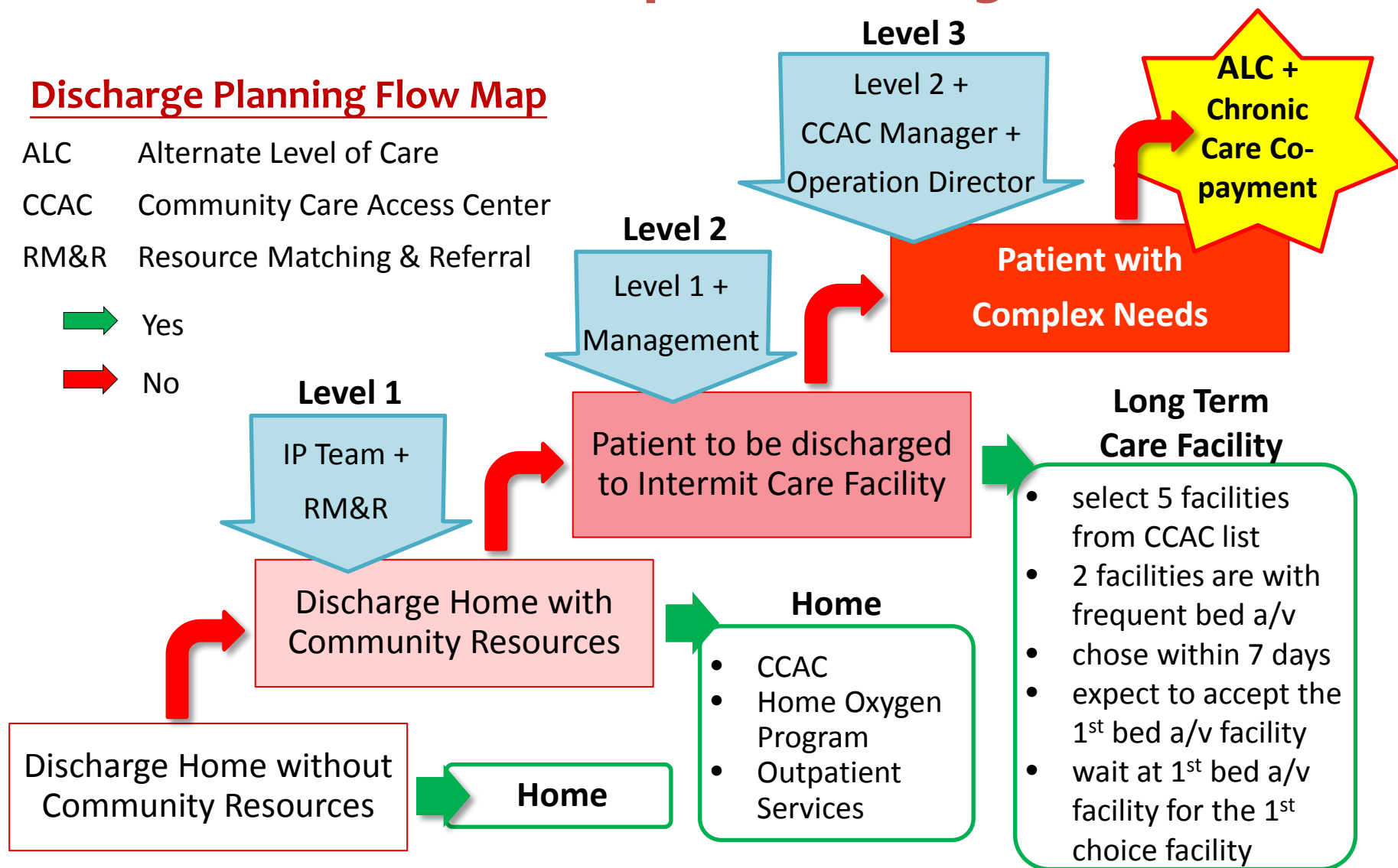
ALC Alternate Level of Care
CCAC Community Care Access Center
RM&R Resource Matching & Referral



Yes



No





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

WAIT TIME STRATEGY
Better Access to Care

In Ontario people also line up to get OUT of the hospital.

The SOLUTION is at our doorstep.
Join us in taking the first step.

Provincial ALC Definition

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated **Alternate Level of Care (ALC)** at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

For further information please email us at
ALCdefinition@cancercare.on.ca or contact your ALC Site Lead

ALC Site Lead

Ontario

Ontario ALC

