Restorative Care:
The Alberta Example

CLPNA 2015
“Planning for the Future Think Tank”
November 10, 2015
Continuum of Care

Right Care
Right Place
Right Team
Edmonton Zone Rehabilitation and Restorative Care

- Developed a conceptual model for rehabilitation and restorative care
- Developed a high level implementation plan
- Applying Restorative Care principles and best practices across the care continuum
- Maximize client outcomes and functional abilities
- Enabling collaborative, seamless and timely transitions
- Alignment with the AHS / Edmonton Zone priorities:
  - 2030 Plan
  - Alberta Health Dementia Strategy
  - CoAct
  - Destination Home
  - Elder Friendly Care
Edmonton Zone: Background

• Current population of 1.23 million is projected to increase by 30% by 2030, 19% will be 65 years and older.
• The oldest “old”, those $\geq 80$ years, will increase from 3% (2012) to 6.4% (2041) for an absolute increase of over 268,000 seniors.
• 8% of seniors meet the clinical and functional criteria for frailty and have the highest levels of health care resource utilization.
• 26% of frail seniors experience a sudden loss of mobility or other function due to chronic disease exacerbation, illness or injury.
FACTS

• **Up to 65% of older adults** who are independent in their ability to walk **will lose their ability to walk** during a hospital stay *(Immobility Ambulation Guideline, updated October 2014. A Choosing Wisely initiative from the American Academy of Nursing)*

• **Hospitalized older adults** who were ambulatory during the 2 weeks prior to admission **spent a median of 43 minutes per day standing or moving** *(JAGS 2009;57:1660-5.)*

• **Without mobilization, older adults lose 1 to 5% of muscle strength each day** *(Annals Int Med 1993;118:219-23.)*
• 1/3 of older adults develop a new disability in an activity of daily living during hospitalization

• Half are unable to recover previous function, leading to loss of independence, medical complications, caregiver burden, avoidable hospitalization, premature continuing care placement and increased mortality. (JAGS 2003;51:451-8)
Restorative Care Recommendations:

Don’t:

• let older adults lie in bed or only get up to a chair during their hospital stay
• use physical restraints with an older hospitalized patient

*Immobility Ambulation Guideline*
updated October 2014.
A *Choosing Wisely* initiative from the American Academy of Nursing
Restorative Care

Definition:
• Interventions which focus on maximizing an optimal level of functioning, enabling individuals to regain and/or retain their independence following the debilitating effects of illness or injury

Goals:
• Promote individuals being discharged to the lowest level of care
• Avoid decisions about continuing care placement being made in acute care
Restorative Care

• Focuses on:
  – Establishing an individualized, goal oriented plan of care
  – Improving mobility, physical functioning and Activities of Daily Living (ADL)
  – Normalizing daily routines and activities
  – Helping individuals “do for themselves”
  – Strengths and abilities rather than disabilities
Continuing Care Restorative Care Unit Model

Phase I – CapitalCare Norwood
  – 45 Beds (April 2014)

Phase II – CapitalCare Grandview, Edmonton General Continuing Care Centre & CapitalCare Norwood (expansion of 16 beds)
  – 37 bed expansion (April 1, 2015)

Phase III
  – Direct Access Priority Process for Community Admissions
RCU Implementation Pillars

- The individual and their family are the centre of the care team
- Evaluation of the individuals ability to participate in their own care
- Individualized goals set within the first 24-48 hours
- Baseline measurement of functional status on admission and discharge
RCU Implementation Pillars (cont)

• Interdisciplinary care model which provides medical monitoring and 7 day per week rehabilitation

• Discharge planning begins on the day of admission

• Supported and collaborative discharge plans with active involvement of home care, family physician and community pharmacy.
Culture and Practice Change

- Staff were asked to be active participants and collaborative partners
- Change must be supported by facts, best practice and make “sense”
- Staff had to understand why the change was needed
- Everyone felt passionate about the vision (even if it was frightening)
Culture and Practice Change (cont)

• View the individual as a “person” and not a patient
• Provide support, transparency and communication to staff, patients and families
• Involve all stakeholders – Acute Care, Home Care, family physicians and community pharmacies
• Provide case studies to establish a clear understanding of Restorative Care
Culture and Practice Change (cont)

- Modify forms and purchase equipment
- Celebrate successes
- Identify challenges and brainstorm solutions
- Watch the transformation begin…
Success Story

• An 81 old female admitted to Acute Care with a fractured hip following recurrent falls & weakness. She also had bilateral knee replacements and osteoarthritis.
• The acute care discharge plan was to admit to LTC
• She was admitted to RCU deconditioned and weak, required total care with ADL’s
• A goal directed action plan was initiated…
• Discharge Planning:
  – began early in her RCU stay
  – involved periodic, regular contact with home care and included staff from the private assisted living site
  – included early planning for equipment needs
Success Story (cont)

- Staff supports focused on improving independence with ADL 7 days per week
  - rehab seated group exercises
  - standing tolerance exercises
  - sit/stand exercises
- Modified Barthel Score went from 3 to 12/20
- 39 day length of stay in RCU
- Returned to her home in assisted living with:
  - Home Care supports and
  - A referral to a comprehensive day program - Comprehensive Home Option of Integrated Care for the Elderly (CHOICE)
LPN: A pivotal role in Restorative Care

- Ability to view the individual from a holistic, strengths based perspective and understanding the individual as a “person”
- Active participation in supporting the individual to meet their goals – doing with, not for
- Understanding of geriatric care
- Working to full scope of practice
- Developing leadership, mentorship and critical thinking skills
- Enable hope and improve quality of life
- Career fulfillment
Restorative Care Results for April 16, 2014 – September 30, 2015

- Average age: 80 years – complex care requirements with multiple co-morbidities and significant frailty
- Occupancy rate: 98%
- Admissions: 414 Discharges: 369
- 88% improved their functional abilities (modified Barthel score)
- 49% returned home with or without community supports
- 21% were admitted to Supportive Living or Facility Living
- 17% returned to acute care
- Average Length of Stay: 46 days overall; for those going home: 42 days
- Median Length of Stay: 37 days overall; for those going home: 31 days
Restorative Care Evaluation (October 2014 to January 2015)

• Achieving the intended goals
• Patients are engaged in their care decisions and outcomes
• Supporting practice and role changes for staff
  ➢ Role clarity
  ➢ Training and support
  ➢ Communication, collaboration and flexibility attributes
• Staff identified the patient progress and person centered care focus as being very rewarding
• Continued work is required to address system gaps in order to provide seamless transitions and improved system flow
HOME IS YOUR BEST OPTION
The longer you stay in an acute hospital bed, the more likely you may:

- Lose strength and energy
- Have a harder time walking
- Experience a fall
- Pick up an infection

Once you’re ready to be discharged, it’s best to get the care you need while you recover at home and in your community.

We’ll work with you to plan for your care needs and make sure support services are in place to help you stay at home safely, for as long as possible.

“Destination Home is about supporting you to be independent and active.”

Community Care Access is your single point of contact for integrated home care. You can call 24/7 with questions about continuing care services.

Call now 780.496.1300
RCU Next Steps

• Review of RCU Admission Criteria and define patient population groups
• Continue to educate acute care transition coordinators about the RCU program
• Refine the staffing model
• Strengthen discharge planning with community partners: family physicians, home care, community pharmacy
• Direct admissions from the community and Emergency Department
• Post-acute Program review
Questions?

GOALS
COMMUNITY
outcomes
PATIENT-FIRST
FUNCTION
home
QUALITY
partners
RESTORATIVE
REHABILITATION