

# From Desperate Providers to Effective Providers: A video deconstruction to inform effective strategies for rehabilitating older adults with dementia

May 5, 2014, GTA Rehab Network

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# Outline

- **Introduction**
  - **Session objectives**
  - **Care delivery to patients with fractured hips in the GTA**
  - **REAP model**
- **Video review (“The Desperate Provider”) and discussion**
- **Care strategies according to REAP**
- **Conclusions**

# Objectives for today's session:

1. Identify the 4 components of the REAP model
2. Describe positive and negative behaviours that enable or disable effective communication with elderly patients with dementia
3. Identify appropriate inter-professional interventions to care for this complex population

# Setting the Context

- **Fractured Hip Rapid Assessment and Treatment (FRHAT) Program developed in 2006**
- **For the pre-rehabilitation phase, two main changes were recommended to acute care based on best available evidence:**
  - **(1) hip fracture patients admitted to acute care hospitals would receive surgery within 48 hours, and**
  - **(2) medically stable, community-dwelling patients would be discharged from acute care to inpatient rehabilitation on Day 5 post-surgery, regardless of fracture type, weight-bearing status, or cognitive function.**

# Setting the Context

- For the rehab phase patients began their inpatient stay which consisted of these five components: (a) rehabilitation management post surgery with a focus on return to pre-morbid function, (b) dementia management, (c) delirium management, (d) staff education and support, and (e) family and patient education. This component is referred to as the **Patient Centered Rehabilitation Model of Care – Targeting persons with CI (PCRM-CI)**
- **High tolerance – short duration (2 to 4 weeks)**
- **Triage decision meeting was held between Days 7 and 10 to determine the patient was at their best location for rehabilitation. Patients remained on the MSK unit**

# Setting the Context

- **Post-rehabilitation care involved transferring patients back to their pre-admission location (i.e., the community). With commitment from the community care access centers (CCACs), the patients had access to further home-based rehabilitation if outpatient rehabilitation was not logistically feasible.**
- **A follow-up clinic appointment was established at the rehabilitation facility to provide follow-up care for patients 6 to 8 weeks post-surgery.**

# PCRM-CI Model Of Care

- ❑ **Implemented at Hillcrest**
- ❑ **Successful outcomes achieved:**
  - **Discharge to retirement home (enhanced care vs. independent living)**
- ❑ **CIHR funding was acquired to replicate in two units outside of the GTA with positive outcomes**

McGilton, K.S., Calabrese, S., Davis, A., Mahomed, N., & Flannery, J. (2009). Outcomes for older adults in an inpatient rehabilitation facility following hip fracture (HF) surgery. *Archives of Gerontology and Geriatrics*. 49(1), e23-e31

McGilton, K.S., Davis, A., Naglie, G. Mahomed, N., Flannery, J. , Jaglal, S., Cott, C., & Stewart, S. (2013). Evaluation of patient-centered rehabilitation model targeting older persons with a hip fracture, including those with cognitive impairment. *BMC Geriatrics*, 13(1), 136

*GTA REHAB NETWORK: BEST PRACTICE GUIDELINES FOR HIP FRACTURE:*

<http://www.gtarehabnetwork.ca/hip-fracture>

# Patient Centred Approach

Patient centred approach to care is a component of PCRM-CI targeting CI patients; it has four underlying principles

The four underlying principles which constitute the REAP Model are:

- Relate Well
- Environmental manipulation
- Abilities focused care
- Personhood

# REAP Approach



- ❑ **Staff' ability to relate well with the patients is essential; staff are taught effective communication strategies to compensate for patient's loss of cognitive reserve** *(McGilton, 2012)*
- ❑ **Environment-person theory** *(Lawton, 1989)* **argues for the need for synergy between person and environment. The social and physical environment must be modified to accommodate persons' changing needs and preferences**



# REAP Approach

- ❑ **Abilities focused care** involves HCP's focusing on patients' retained abilities not on their disabilities  
*(Dawson and Wells, 1993)*
  
- ❑ **Personhood** *(Kitwood, 1999)* refers to knowing the patient as a person, involves becoming familiar with the individual and gaining knowledge of a person's life. This process may involve partnering with families to gain needed knowledge

# Video Case Example

With credit to Mary Grace Grossi and Dr John Flannery for their leadership

# The Case of Mrs. D

- ❑ Admitted to an in-patient rehabilitation MSK Program

## HPI:

- ❑ Unwitnessed fall in her apartment. She was found by her daughter a few hours later
- ❑ Left hip fracture – Left Bipolar Hemiarthroplasty (precautions in place)
- ❑ Post-op elevated confusion and disorientation. Acute care transfer notes report increased wandering and episodes of agitation (ie/ yelling and throwing objects)

## PmHX:

- ❑ HTN
- ❑ DM II
- ❑ Dementia (diagnosed 1 month ago)
- ❑ Macular Degeneration and decreased hearing in left ear



# The Case of Mrs. D

## Social:

- Lived in one bedroom apartment
- 2 daughters in Toronto (one POA for finances and the other POA for self care)
- Enjoyed weekly outings with daughter and friends
- Retired nurse

## Pre-Fall Function:

- Previously independent in most self care activities (except showering) and light homemaking.
- Independent transfers. Ambulated using a rollator walker

# Video Scene 1

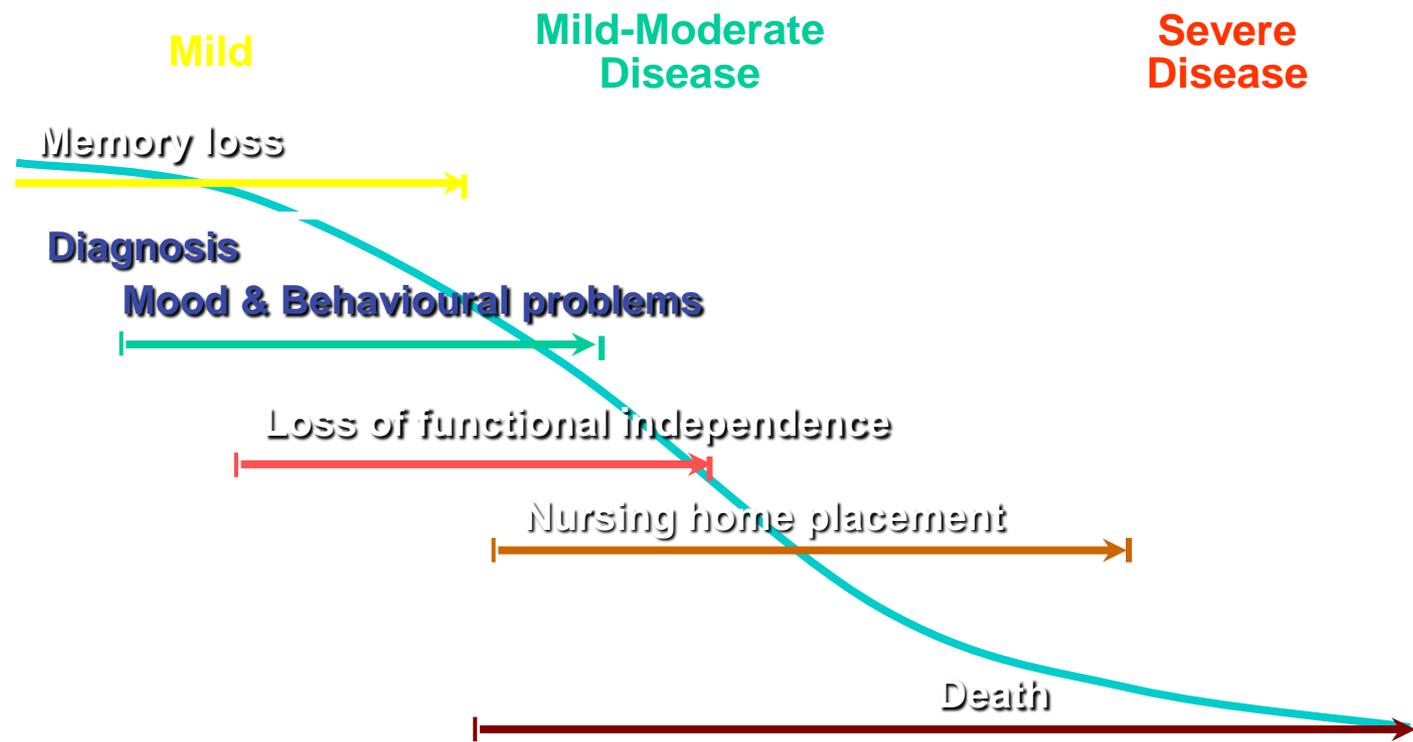
# Cognitive disorders on the Rehab Unit

- Dementia
- Delirium
- Depression
- Mild Cognitive Impairment (MCI)

# What is dementia?

- Clinical diagnosis based on agreed upon criteria without a lab test most cases
- Permanent injury to cognitive ability
- Strict criteria: 2 or more areas of cognition(memory, language, calculation, praxis, executive fn, concentration, spatial ability and loss of prior functional ability

# Course of the Disease



# Delirium

- Acute onset
- Fluctuation of Consciousness and Cognition
- Acute illness
- 25% of community seniors in hospital
- 75% of institutional seniors in hospital
- 90% over in 30 days

# Mild Cognitive Impairment (MCI)

A persistent abnormality in one cognitive domain only in the absence of functional loss

- MCI amnesic type- short term memory loss is the most common 90%
- MCI 20% of seniors prevalence
- MCI high risk of conversion to dementia Alzheimer's commonly 10-15% annually

# Barriers to Early Detection

- World wide, over half of all dementia cases may go unrecognized in primary care practices
- Barriers to the identification, assessment and management of dementia identified by Canadian primary care physicians included:
  - Limited experience with dementia
  - Diagnostic uncertainty
  - Lack of access to resources (e.g., specialists, CT)
  - Lack of time
- Common perception that dementia is a part of normal aging can also be a barrier to early detection

# Screening for Cognitive Impairment

- Current evidence does not support routine screening of patients in whom cognitive impairment is not otherwise suspected
- Clinicians should assess cognitive function whenever cognitive impairment or deterioration is suspected, based on:
  - Direct observation
  - Patient report
  - Concerns raised by family members, friends or caregivers

# What is Comprehensive Geriatric Assessment?

- Systemic evaluation of a frail older person by a team of health care professionals can uncover treatable health problems and lead to improved health outcomes

# 4 Dimensions of CGA

CGA

Physical  
Health

Functional  
status

Mood and  
Cognition

Socio environmental  
factors

Problem list  
Comorbid conditions  
and  
disease severity  
Medication review  
Nutritional status

Basic activities of  
daily living  
Instrumental activities of  
daily living  
Activity/exercise status  
Gait and balance

Mental status (cognitive)  
testing  
Mood/depression  
testing

Informal support needs  
and assets  
Care resource eligibility/  
financial assessment  
Environmental assessment  
Home safety  
Transportation and  
telehealth

# Comprehensive geriatric assessment for older adults admitted to hospital (Review) 1

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## Main results

- Twenty-two trials evaluating 10,315 participants in six countries were identified. Patients in receipt of CGA were more likely to be alive and in their own homes at up to six months (OR 1.25, 95% CI 1.11 to 1.42,  $P = 0.0002$ ) and at the end of scheduled follow up (median 12 months) (OR 1.16, 95% CI 1.05 to 1.28,  $P = 0.003$ ) when compared to general medical care.
- In addition, patients were less likely to be institutionalized (OR 0.79, 95% CI 0.69 to 0.88,  $P < 0.0001$ ).
- They were less likely to suffer death or deterioration (OR 0.76, 95% CI 0.64 to 0.90,  $P = 0.001$ ),
- and were more likely to experience improved cognition in the CGA group (OR 1.11,
- 95% CI 0.20 to 2.01,  $P = 0.02$ )
- Subgroup interaction in the primary outcomes suggests that the effects of CGA are primarily the result of CGA wards.

# Comprehensive geriatric assessment for older adults admitted to hospital (Review) 1

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## Authors' conclusions

- Comprehensive geriatric assessment increases a patient's likelihood of being alive and in their own home at up to 12 months

## Plain language summary-comprehensive geriatric assessment for older adults admitted to hospital

- This review investigates whether specialist, organised and co-ordinated geriatric care CGA is better for patient outcomes than conventional care in a hospital setting
- There is a clear and significant Improvement in the chances of a patient being alive and in their own home at up to a year after an emergency hospital admission if they receive co-ordinated specialist services
- This effect is consistently seen from trials of geriatric wards where patients are admitted to a dedicated ward area and receive care from a specialist multidisciplinary team
- This effect was not clearly seen where patients remained In a general ward and received assessment from a visiting specialist multi-disciplinary team

# Video Scene 2

# REAP in action

## Relating well to Mrs. D:

- Call her by her preferred name
- Daily verbal reminders of where she is and why, date
- Consistent team members working with her
- Calm voice and body language
- Speaking to her right ear (as left ear has decreased hearing)
- One step verbal commands
- Eye contact and “gentle” touch for physical cueing

# Team Initial Ax Findings on Admission

## **Physical:**

- Increased left hip pain reported by patient
- Generalized deconditioning & decreased endurance
- Incontinent bladder and bowel

## **Cognition & Psychosocial Status:**

- CAM – delirium indicated
- MMSE screen 13/29 (“moderate” cognitive challenges)
- Decreased memory, orientation (time and place)
- “Restless” and increased wandering risk (at all times)
- Cueing required for all activities

# Team Initial Ax Findings on Admission

## **Mobility & Transfers:**

- WBAT, standard hip precautions
- Bed Transfers: mod assist x 1
- Sit to stand: min. assist x 1
- Ambulation with 2ww and min. assist x 1 for a few steps only
- Stratify Falls Risk Assessment – HIGH Fall Risk

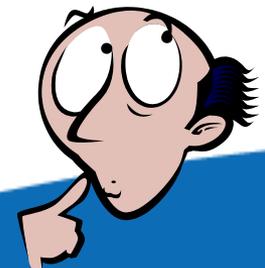
## **Self Care:**

- Moderate assistance x1 for all self care activities
- Cueing – verbal and physical cueing required for all self care activities



# Team's Presenting Considerations for Mrs. D

- ❑ High Falls Risk: decreased mobility, decreased vision, decreased hearing, cognition
- ❑ Significant hip and shoulder pain impacting function
- ❑ Wandering risk and “getting out” of bed and/or wheelchair frequently
- ❑ Decreased environmental orientation
- ❑ Behavioral responses – yelling, throwing
- ❑ Increased sleeping during the days and minimal at night
- ❑ Incontinence bladder & bowel
- ❑ Increased care needs → Supervision/assistance and cueing required for all activities



# Video Scene 3

# REAP in action: A Team Approach

## Environment for Mrs. D:

- ❑ Low vision strategies – lighting, contrast, de-clutter for safety, using large print
- ❑ Orientation signage: calendar, patient room, wayfinding signs
- ❑ Consistent schedule by team for Mrs. D including:
  - Toileting routine
  - Consistent daily therapy times
  - Self care activities

**E**

# REAP in action: A Team Approach

## More Environment Strategies for Mrs. D:

- ❑ “Restless/Wandering” strategies:
  - use of volunteers for recreational activities
  - room located close to nursing station
  - minimize room switches
  - consistent therapy and activities spread out throughout the day
  - seated in wheelchair with activities to do close to team care desk during the days
  - roam alert bracelet
- ❑ Fall prevention strategies implemented (ie/ use of high-low bed with bed alarm, floor mats for nights, wheelchair alarm in place)

# REAP in action: A Team Approach

## Abilities focus for Mrs. D:

- ❑ Maximizing upon remaining visual abilities
- ❑ Focus on “functional activities” versus standard exercises by OT and Physio
- ❑ Consistent daily team communication and encouragement of Mrs. D in “what she can do”
- ❑ Consistent performance of mobility and care activities with Mrs. D by all team members

A

# Video Scene 4

# REAP in action: A Team Approach

## Person-alizing Mrs. D:

- ❑ Lifelong sensitivity to temperature changes:
  - Noted increased anxiety and agitation when cold
  - use of warm blankets for comfort and ensuring warmer temperature as a strategy
- ❑ Recognition of past roles/activities:
  - performed “admin” activities in nursing station for nurses
  - Talking to her about her past interests/roles (staff and volunteers)
- ❑ Pain – use of primarily non-pharmacological modalities (distraction, relaxation, deep breathing, hot packs)
- ❑ Daughter asked to stay for the first day – good way to get to know the patient

# Video Scene 5

# “REAP”-ing the Rehab Results & Outcomes

## Functional Outcomes for Mrs. D:

a) **Self Care:** supervision for dressing and bathing activities only.

## b) **Physical:**

- ambulating with 2ww around the unit with supervision and cues for way-finding only
- independent transfers to bed, chair, toilet
- tolerating 1 to 2 hours of therapy OT/PT daily

## c) **Wandering/Orientation:**

- increased orientation to the unit and her room with strategies in place
- significantly decreased wandering and behavioral responses with team strategies and consistent routine in place; delerium resolved

# “REAP”-ing the Rehab Results & Outcomes

## Team Recommendations for Discharge:

- Supervision for self care activities
- Supervision for community ambulation (remains wandering risk)
- Daily “check-ins” required at various intervals during the day
- Link up to meals & homemaking supports
- Environmental recommendations made for wandering and cognition status by OT & PT
- Equipment recommendations for safety
- Link to Wandering Registry (Alzheimer’s Society)
- Socialization – link to Day Program, community senior’s activity groups, friendly visitor program



# Interprofessional Team Reflections



- ❑ Older adults with cognitive issues are rehab – “able”
- ❑ Open team communication and consistent processes: use humor, listen to each other, challenge opinions
- ❑ REAP framework to guide our patient-team interactions & interventions
- ❑ Patient – family/caregiver -community partnership throughout rehab process (expectations have changed)
- ❑ Discharge destinations vary but 90% go back home
- ❑ Team reflection of challenging cases and successes

- Questions?