Rehabilitative Care Alliance

Ontario Local Health Integration Network

Hip Fracture & TJR Self-Assessment High Performers

Best Practice Implementation Strategies

February 2019

Rehabilitative Care Alliance

Overview of Self-Assessment Process

- The Rehabilitative Care Alliance (RCA) released two best practice frameworks in 2017:
  - *Rehabilitative Care Best Practices Framework for Patients with Hip Fractures*
  - *Rehabilitative Care Best Practices Framework for Patients with Primary Hip and Knee Replacements*
- The frameworks support implementation of QBPs with detailed best practices for rehabilitative care across all care settings: pre-operative (TJR), bedded, ambulatory, in-home and long-term care (hip). Quick reference guides for each setting provide a concise summary of best practices to guide clinical practice.

Rehabilitative Care Alliance

Overview of Self-Assessment Process

- The Rehabilitative Care Alliance undertook a provincial self-assessment process which allowed health service providers to determine how well their current care aligns with best practices set out in the RCA's rehabilitative care best practice frameworks for hip fracture and primary hip and knee replacements.
- Self-assessment tools were released in January to health service providers with a deadline of May 4, 2018. This deadline was extended to ensure that all organizations had the opportunity to complete their self-assessments. Final self-assessments were received July 13, 2018.
- The RCA received 247 self-assessments (116 Hip Fracture/131 TJR) from 104 organizations across all 14 LHINs.

Rehabilitative Care Alliance

Self-Assessment High Performers

- Those who were identified as high performers through the self-assessment process were all or mostly aligned with hip fracture or total joint replacement best practices

- Best practice implementation strategies from the high performing programs in each sector are shared below to promote knowledge exchange. The following implementation strategies are shared:
  - Strategies to address the identified provincial opportunities for improvement
  - Creative or innovative ideas that have successfully implemented best practices

Rehabilitative Care Alliance

High Performers – All or Mostly Aligned

Hip Fracture

- Bedded
  - Halton Healthcare
  - Grand River Hospital
- Ambulatory
  - Halton Healthcare
- In-Home
  - Mississauga-Halton St. Elizabeth
- LTC
  - Heidehof
  - Radiant Care Pleasant Manor

Total Joint Replacement

- Pre-operative Care
  - St. Joseph's Healthcare Hamilton
  - Halton Healthcare
  - Sunnybrook Health Sciences
  - Peterborough Regional
  - Queensway-Carleton
- Bedded
  - Cambridge Memorial
  - Grand River Hospital
  - Brant Community Healthcare
  - Dundurn Place
  - Peterborough Regional
  - Providence Care
  - Queensway-Carleton
- Ambulatory
  - Grand River Hospital
  - Providence Healthcare
  - Sunnybrook Health Sciences
  - Pembroke Regional
- In-Home
  - Waterloo-Wellington LHIN

*Permission obtained to share the names of high performing organizations

Rehabilitative Care Alliance

Ontario Local Health Integration Network

Hip Fracture Best Practice Implementation Strategies

• • •

Rehabilitative Care Alliance

Hip Fracture Bedded: Best Practice Implementation Strategies

- Co-locate hip fracture patients on 1 unit with a dedicated, interdisciplinary team[2]
- Utilization of unique program team members to assist in meeting best practices:
  - Professional Practice Clinician dedicated to Safe Elder Care practices[2]
  - Early access to Geriatrician[1]
  - Internal Medicine Reviews[1]
  - Osteoporosis Canada Fracture Prevention Coordinator[1]
  - Surgeon Best Practice Champions[1]
- Geriatric Hip Fracture Pre and Post-op Order Sets[2]
  - Automatic orders for delirium prevention
  - Care path for delirium includes no night sedation, non-pharmacological sleep protocol, re-orientation
  - Healthy Bone Treatment
  - Pharmacy assessment within 48 hours

[1]Grand River Hospital
[2]Halton Healthcare

Ontario Local Health Integration Network

Rehabilitative Care Alliance

Hip Fracture Bedded: Best Practice Implementation Strategies (continued)

- HELP Program (Hospital Elder Life Program) – (delirium prevention) a multicomponent intervention strategy utilizing a targeted interdisciplinary geriatric assessment and an innovative volunteer model with a structured curriculum, including daily orientation, early mobilization, feeding assistance, therapeutic activities, non-pharmacological sleep protocol and hearing/vision adaptations www.hospitalelderlifeprogram.org [1, 2]
- Music & Memory Program – (dementia care) taps deep emotional recall which improves relationship building, eases transitions, avoids challenging behaviours and saves time. www.musicandmemory.org[2]
- Staff training in Gentle Persuasive Approach (dementia care) [2]

[1]Grand River Hospital
[2]Halton Healthcare

Ontario Local Health Integration Network

Rehabilitative Care Alliance

Hip Fracture Bedded: Best Practice Implementation Strategies (continued)

- Therapists are BONEFIT certified (osteoporosis management)[2]
- Patient & Family Advisors assist with the development of all patient materials and videos[2]
- Patient entertainment arms have research modules for patients and families to search medical information. For example, diagnoses and medications. [2]
- Transfer of accountability provided to next health care provider and linkages to community resources[2]
- Therapy coverage during off hours. For example, changing a physiotherapist's work day to 1400-2200 to provide evening coverage and PT/OT weekend coverage[1]

[1]Grand River Hospital
[2]Halton Healthcare

Rehabilitative Care Alliance

Hip Fracture Ambulatory: Best Practice Implementation Strategies

- Transfer of Accountability from Bedded Sector
- Involvement of families and caregivers, including information regarding “what to watch for” for delirium
- Staff training in Gentle Persuasive Approach
- Motivational Interviewing techniques utilized
- Interdisciplinary teams from multiple ambulatory clinics are co-located to allow for team rounding/huddles to develop best strategies for individual patient care
- Interdisciplinary teams include PT, OT, SLP, Nursing, Nurse Practitioner, Social Work and Geriatrician

Halton Healthcare

Rehabilitative Care Alliance

Hip Fracture In-Home: Best Practice Implementation Strategies

- Delirium/Dementia/Depression strategies:
  - Embedded in therapy initial assessment form
  - 3Ds Standardized Outcome Measures: SIGECAPS, Geriatric Depression Scale, Mini-Cog, MoCA, Confusion Assessment Method (CAM)
- Rehabilitation treatment sessions average 8 weeks 2-3 visits/week using a PT-PTA care model
- BONEFIT certified therapists act as Osteoporosis Practice Champions
- Team meetings are focused on reflective clinical practice, peer to peer collaboration, case reviews and coaching to implement best practice

SE Health – Mississauga-Halton LHIN

Rehabilitative Care Alliance

Ontario Local Health Integration Network

Total Joint Replacement Best Practice Implementation Strategies

• • •

Rehabilitative Care Alliance

TJR Pre-operative Care: Best Practice Implementation Strategies

- Prehab Program
  - Mandatory attendance (utilizing bundled funding)[1]
  - In person prehab classes or prehab video 2-3 months prior to surgery[1, 2]
  - Early screening for transition planning[1, 2, 3, 4]
  - High risk patients are immediately engaged by Social Work, Discharge Planning and/or Inpatient Rehabilitation Manager[1, 2]
  - Individual meetings with PT, OT, Fracture Clinic Nurse to assist with planning for equipment, care concerns and special needs[1, 2, 3, 4]
  - Special needs communicated with managers on inpatient, OR, PACU, Day Surgery and Pre-op Clinic[3]

[1] Halton Healthcare
[2]Peterborough Regional Health Centre
[3]St. Joseph's Healthcare Hamilton
[4]Sunnybrook Health Sciences Centre

Rehabilitative Care Alliance

TJR Pre-operative Care: Best Practice Implementation Strategies (continued)

- Advanced Practice Physiotherapist/Intake Clinic screens surgical versus conservative treatment[2, 3, 4]
  - Those exploring conservative measures are offered GLA:D program and other osteoarthritis best practice treatments[4]
  - Outcome measures: Sit-stand chair test, Timed Up & Go, 40 Metre Walk Test, LEFS[4]
- Mobile app provides pre-op education, reminders for pre-op preparation and post-op self-management[1, 4]
  - Families are included to assist with the use of the app, as needed

[1] Halton Healthcare
[2]Peterborough Regional Health Centre
[3]St. Joseph's Healthcare Hamilton
[4]Sunnybrook Health Sciences Centre

Rehabilitative Care Alliance

TJR Bedded: Best Practice Implementation Strategies

- Patient & family education
  - Align Engage Program in Convalescent Care – lectures and materials include lifestyle modification information[1]
  - Lifestyle modification education provided in Intake Clinic or by surgeon[3, 5]
  - Videos providing education reviewed with patients and available on website for patients/families[5]
  - Ortho Surgical Passport Booklet/ Admission package and discharge summary provided[5, 6]
- Early mobilization
  - Abductor canal blocks allowing mobilization Day 0[2]
  - Anterior approach THR allowing potential discharge Day 1[2]
  - Patients not catheterized intraoperatively. Ambulation to washroom Day 0.[3]
  - Physiotherapy Day 0[3]

[1]Dundurn Place Convalescent Care
[2]Brant Community Health Centre
[3]Cambridge Memorial Hospital
[4]Grand River Hospital
[5]Peterborough Regional Health Centre
[6]Providence Care

Ontario Local Health Integration Network

Rehabilitative Care Alliance

TJR Bedded: Best Practice Implementation Strategies (continued)

- Multimodal pain management led by Department of Anesthesia and support by a Nurse Practitioner[3]
- Total Joint Replacement Clinical Nurse Specialist[4]
- Therapy coverage during off hours. For example, changing a physiotherapist's work day to 1400-2200 to provide evening coverage and PT/OT weekend coverage[2, 4]
- Transition planning
  - LHIN Home & Community Care contacts patient prior to surgery to advise on equipment and physiotherapy follow up[3]
  - Blaylock score in pre-op identifies previous functional status and potential barriers for discharge[4]

[1]Dundurn Place Convalescent Care
[2]Brant Community Health Centre
[3]Cambridge Memorial Hospital
[4]Grand River Hospital
[5]Peterborough Regional Health Centre
[6]Providence Care

Ontario Local Health Integration Network

Rehabilitative Care Alliance

TJR Ambulatory: Best Practice Implementation Strategies

- Patient & family education:
  - Provided via classes, 1:1, patient guide, post-op exercise booklet and mobile app[1, 2, 3]
  - Education includes managing meaningful tasks while adhering to hip precautions and lifestyle modification[2]
  - Education is reviewed and updated regularly with changes in practice and evidence[3]
  - Comprehensive fall prevention screening initiative – all patients 65+ years complete the "Staying Independent Checklist". Those who score at risk receive education from the health practitioner and are encouraged to see their primary care practitioner[1]

[1]Pembroke Regional Hospital
[2]Providence Healthcare
[3]Sunnybrook Health Science Centre

Rehabilitative Care Alliance

TJR Ambulatory: Best Practice Implementation Strategies (continued)

- Outcome measures utilized[1, 2, 3]:
  - LEFS
  - TUG
  - COPM
  - Numeric Pain Scale
  - 2 minute walk test
  - 1 RM leg press
  - Stair test
  - P4
  - PSFS
- Therapists are BONEFIT certified[2]
- Process in place to maintain consensus among surgeons regarding post-surgical care to create consistent evidence-based care[3]

[1]Pembroke Regional Hospital
[2]Providence Healthcare
[3]Sunnybrook Health Science Centre

Ontario Local Health Integration Network

Rehabilitative Care Alliance

TJR In-Home: Best Practice Implementation Strategies

- Patient & family education:
  - LHIN-wide regional education booklet for hip and knee surgery (http://regionalhealthprogramsww.com/PatientEducationMaterial?deptID=2)
  - Implementation of a mobile app is in process to provide patients with information and planning for surgery
  - Best practice standard document for all aspects of the care pathway (http://regionalhealthprogramsww.com/HealthCareProviders/CarePathways/TotalJointArthroplasty?deptID=2)
- Outcome measures (http://regionalhealthprogramsww.com/HealthCareProviders?deptID=2)
- Transition planning:
  - Patients are seen in home and clinic by the same physiotherapist
  - LHIN Home & Community Care team calls patients 6 weeks prior to surgery to facilitate transition planning and preparations

Waterloo-Wellington LHIN Home & Community Care

Rehabilitative Care Alliance

Contact Information

For questions, contact:

info@rehabcarealliance.ca