

June 3, 2013

Ms. Catherine Winckler 718 Millyard Street Vancouver, BC V5Z 4A1

Dear Ms. Winckler:

I am pleased to write again in response your letter of April 12, 2013 directed to Fraser Health Board Chair David Mitchell in which you requested an update on the status of actions taken by Fraser Health to address your family's questions and the recommendations arising from the Coroner's Inquest into your mother's passing while in care at Chilliwack General Hospital (CGH) in March 2000.

Since 2008 Fraser Health has been organized under a Program Management model. This means that all the services and programs offered at individual sites such as CGH are managed Fraser Health-wide. This ensures coordination and continuity as patients transition from one phase of care and/or location to another. Improvements made by the clinical programs are implemented at all the sites where care is delivered, allowing for standardization of leading practices across Fraser Health.

In the past few years, as Program Management has become well-established in Fraser Health, many changes have been made in the way care is communicated, delivered, and documented. Great strides have been made in improving patient safety, with particular attention paid to areas highlighted by Accreditation Canada such as medication reconciliation, the use of surgical safety checklists, care transition management, teamwork and communication, and culture. Central to all of this is partnerships between patients and their families and the health care team. Our Patient Advisory Council has been functioning for two years and has a very active role (supported by our Board and Executive team) in building a focus on partnership. We are redesigning care through a "Seamless Care" strategy, which has at its center the patients and families as our partners, and focuses on making the experience of our care and services as safe, effective and efficient as possible.

Fraser Health's initial responses to your family in 2003 are cited below in bold, followed by an update including examples of activities undertaken since that time across Fraser Health.

1. "A chart audit tool has been developed to assist in the evaluation of documentation and in the identification of gaps in patient information. The

## results of this evaluation will be used to make improvements in the documentation system as required."

Since the implementation of the Program Management model in 2009/10, teams have been supported to standardize their documentation, and work is underway to standardize forms that will be used with electronic health records in hospitals. A Documentation Policy was implemented in March 2013, and profession-specific documentation requirements are being developed with a target completion date of March 2014. A review of handover processes has been completed, and processes and tools have been developed to support these care transitions. Work is also taking place to standardize documentation requirements with a focus on patient outcome goals. This includes standardization of the 24-Hour Patient Care Record, Admission Assessment and Interdisciplinary Care Plan.

## 2. "Medical Rounds will review the Winckler case in 2002/03 for educational purposes. The Family Practice Residency Program has already reviewed the case from an educational perspective."

A number of educational initiatives have taken place at CGH over the years. These include numerous lectures to family practice residents, internists and family practitioners on the topics of pain, falls, and medications in the elderly.

The Medicine program has recruited a geriatrician for CGH. The geriatrician has worked with the seniors' clinic, which has resulted in improved quality of care for the elderly population.

Educational rounds, lectures and papers have included dementia protocol.

The 48/6 model of care for hospitalized seniors is to be implemented by the autumn of 2013. This is a Ministry of Health initiative that addresses six key care areas of functioning through patient screening and assessment as well as the development of a personalized care plan within 48 hours of the decision to admit a patient. The six functions critical for good patient-centered care for all hospitalized adults are bowel and bladder management, cognitive function, function mobility, nutritional hydration, medication management and pain management.

Health care practitioners are receiving education regarding the new 2012 Beers Criteria for potentially inappropriate medication use in older adults. The Beers Criteria have done more than any other tool in the past decade to improve the awareness of and clinical outcomes for older adults using multiple medications, and for the most vulnerable older adults at risk of adverse drug events. The new Criteria includes updated research on various drugs, new information about appropriate prescribing of medications for an expanded list of common geriatric conditions, and ratings of the quality of evidence supporting the panel's recommendations.

#### References:

American Geriatrics Society 2012 Beers Criteria Update Expert Panel (2012). American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, Journal of American Society, 60(4):616-631. Beers list can be retrieved from <a href="https://www.americangeriatrics.org">www.americangeriatrics.org</a> on May 17, 2013.

3. "A program that will focus specifically on the care of the elderly or geriatric patient in the CGH acute care units is being developed. To support this program, best practices have been identified and Marcia Carr, Clinical Nurse Specialist and a Practice Consultant from RNABC have contributed expertise to the program components which include: Falls Management/Least Restraint, Pain Management, Incontinence, - Nutrition/Bowel, Management of Challenging Behaviors, and Transfer of Care between Units."

A Least Restraint Clinical Practice Guideline (CPG) was developed and implemented within a year of your mother's passing. This CPG is now standard practice. The Fraser Health Clinical Policy Office also supported the development of these policies and clinical decision support tools to be applied at CGH and across Fraser Health.

The Least Restraint CPG is currently being further revised to support staff to make appropriate care decisions related to alternative strategies to restraint use except in situations where all other efforts have failed. This guideline applies to all Fraser Health clinical programs, and is supported by new documentation and monitoring tools, and a behavior observation record to track and trend patient behavior changes over time so that risks associated with these changes can be effectively mitigated.

4. "Clinical practice guidelines for the use of restraints are currently at the final approval stage and will be ultimately implemented throughout the Fraser Health Authority."

A Least Restraint Policy and related approved equipment have been established and standardized. This has been implemented across Fraser Health. Please see #3 above.

5. "Jocelyn Reimer-Kent, Clinical Nurse Specialist (Pain Management), agreed to assist with the development of evidence-based guidelines and education for pain management. Staff education session on Pain Theory and Guidelines for Pain Management will be completed by October, 2002 and will be an ongoing topic for staff education."

Jocelyn presented to the nursing staff on a Rapid Surgical Recovery (RSR) approach as part of the Reimer-Kent Postoperative Wellness Model. The model addresses the provision of preventive-based care around the issues of pain, nausea, constipation, immobility and respiratory compromise. There was interest in adopting this model as the standard of care for all surgical patients at CGH and other sites in recognition of its potential for improving care outcomes. There is an opportunity to spread this model across Fraser Health under the Program Management model of care delivery.

For more information on RSR, please see article at http://www.cccn.ca/media.php?mid=241] or FH research website for resource manual <a href="http://researchdb.fraserhealth.ca/ersweb/Document.aspx?Id=189">http://researchdb.fraserhealth.ca/ersweb/Document.aspx?Id=189</a>

6. "Professional Practice Councils will be established at each hospital site, including CGH. Terms of Reference have been drafted for these Councils and the inaugural meeting at GCH is scheduled for September 30, 2002 and monthly thereafter. The purpose of this multi-disciplinary council will be to facilitate excellence in

the provision of patient and family centered clinical services and organizational system support. This body can address practice issues such as documentation, pain management and reporting."

As part of the transition to Program Management in 2009/2010, site-based practice councils were dissolved in favor of inter-professional program-based councils. These councils allow for clinical sharing and problem solving, and provide clinical resources and support that focus on client-centered care and outcomes. In addition, much work has taken place since 2004 to establish regional profession-specific councils that focus on advancing practice and improving outcomes for patients, residents and clients.

7. "Where transfers are appropriate, our policy for some time has been that the individual receiving nurse is to conduct an assessment. Staff education will be provided on an ongoing basis."

Staff education related to receiving nurse assessment is an ongoing responsibility of the Unit Manager, Patient Care Coordinator and Clinical Nurse Educator. There is a significant emphasis within care delivery redesign initiatives on patient assessment upon transfer to ensure that concerns are identified and addressed in a timely and effective manner.

8. "A review of current transfer and discharge practices is underway with a goal to ensure that patients are transferred to the appropriate care areas with information that will best meet the patient's need. An examination of the communication of patient care information between units is ongoing - one tangible result is a card of patient's information that accompanies the patient to his/her new ward. Care paths will further promote continuity of care through ongoing assessment and inter-disciplinary communication, with special focus on variations in the processes and outcomes of case and treatment."

Baseline audits of care and discharge planning were coordinated during 2012. A discharge planning process was implemented across the Medicine program, as were as standardized care pathways, which are being spread across programs where applicable. Regular audits are done within the Medicine program to identify opportunities for continuous improvement. A care plan template is being developed and a final document will be ready for pilot and implementation during summer 2013. Review of the transfer process has led to development of tools that will be incorporated into standards for care delivery under Fraser Health's Seamless Care strategy.

9. "As noted in Recommendation 2, a Care Path that specifically addresses the care needs of the elderly or geriatric patient will be implemented in October 2002. The Care path includes the components of restraint use, pain management, sedation and the effects of analgesics on the elderly. An education program for staff to address the same needs will also begin in October and will be ongoing."

Due to the complexity of this patient population, there is no individual Care Path that integrates all aspects of acute care of the elderly patient. However, the Acute Care Geriatric Nurse Network (ACGNN) and Geriatric Emergency Network Initiative (GENI) have made great strides in leading improved care of older adults. The Ministry of Health's Seniors' Hospital Care Working Group has established practice standards to ensure evidence-based,

safe care for older adults in acute care. These standards are specifically related to an initiative entitled 48/6, described in #2 above. A 48/6 Steering Committee, Tools Standardization Working Group, and Implementation Committee have been organized to implement these improvements Fraser Health-wide. At this point, the work is focused on development of a Pre-Admission Screening Questionnaire, Admission Assessment, 24-Hour Patient Care Record, and an Interdisciplinary Care Plan. These tools will apply to patient care across clinical programs.

10. "A number of CarePaths have been revised. As well, we have integrated care paths into individual patient records more effectively and made them a key document for accountability. There are three aspects to these CarePaths: expectations (e.g. degree of recovery to be expected on a given day of a particular illness or condition), addressing variations, end accountability for patient outcomes."

The Fraser Health Surgery program has developed care paths for orthopedic surgeries that identify both risks for problems as well as early identification of a problem. *See attached Total Hip/Knee Replacement Care Path.* 

11. "The revised CarePaths include a variance-tracking tool that capture deviation from expected recovery, specific actions required, and who is responsible for carrying out these actions."

Please see #10 above.

12. "Across the Fraser Health Authority, we are looking at patient alert devices to help deal with such issues as wandering, unsafe bed/chair exits."

Patient alert devices have been implemented. New beds are being purchased have a built-in bed exit alarm. Other examples include the Wander Guard, which is in place in a number of sites, including CGH.

13. "The recommendation was reviewed with a decision to not change the consent process (consent is a process as opposed to simply a form). The issue was determined to be one of process and communication between professionals. It was noted that while the issue should remain at a local or health area, work is underway (Fall 2002) to develop one policy and process (for the FHA)."

In September 2011 Fraser Health implemented a new Consent for Health Care Policy to guide physicians and staff in obtaining informed consent for health care in accordance with legislative requirements and professional practice standards. The policy aims to protect the rights of individuals and promote their full participation in making informed decisions with respect to care and treatment options by ensuring a consistent approach to the consent process across Fraser Health. This includes the requirement for health care providers to document consent discussions and treatment decisions in the health record.

14. "A Practice Consultant from RNABC participates as an ad-hoc member of the Project team to provide expertise on standards of practice and professional

responsibility. In addition, RNABC has assisted in the development of a new program that focuses on the care of the elderly patient in acute care."

The ACGNN and GENI were funded by the Ministry of Health Nursing Directorate for five years. This funding is no longer available. However, Clinical Nurse Specialists continue to collaborate on a voluntary basis to ensure an ongoing focus on the care of acutely ill older adults throughout the province. (www.acgnn.ca)

15. "Dr. Dave Williams, chair of the former Medical Quality improvement Committee of the Fraser Valley Health Region, has sent a letter to the College requesting information regarding what action the College plans to take regarding this recommendation. To date a response from the College has not been received. (Recommendation: That the College or Physicians and Surgeons review this case for educational purposes deemed appropriate)."

The College of Physicians and Surgeons of BC has performed a number of activities over the years involving education to family practitioners. The College has hosted various courses: narcotic use in chronic nonmalignant pain, medical record keeping for physicians, prescribing for patients with chronic pain, ethics and professionalism, and methodne workshops. The College also hosts a yearly education day. This has occurred over the last ten years. As well, the College website has numerous links to other educational organizations as well as professional standards and guidelines. Through the College website family physicians have access to an extensive library that includes Best Practice for up-to-date information for diagnosis as well as access to over sixty medical e-books, evidence-based Canadian drug and therapeutic information, and expert reviews of current diagnoses and treatments in North American clinics. (www.cpsbc.ca)

16. "As one of the initial steps in strengthening patient advocacy in the FHA, Bob Smith, CEO of the FHA, Cathy Weir, Director of Quality Improvement, Risk Management, and Helen Carkner, Director of Communications have met to discuss an FHA approach to customer service ensuring access to information, and opportunities for patients, clients and families to provide feedback and have their concerns addressed. (in Fall 2002). This strategy will be implemented in a timely and effective manner. A component of this will be to provide information brochures to patients and their families."

The amalgamation of the three former Health Regions (Fraser Valley, South Fraser and Simon Fraser) into Fraser Health included the coordination of mechanisms for patients, clients, residents and their families across all our communities to seek information and provide feedback on their experience and ideas for improvement. A Client Relations team established in 2005 plays a key role in assisting individuals by ensuring their questions and concerns are addressed by the most appropriate clinical or support areas. Online access to information and support also available via the Fraser Health (feedback@fraserhealth.ca). In October 2008, legislation was enacted in BC entitled the Patient Care Quality Review Board Act. This legislation, along with Ministry of Health Directives, formalized and standardized the process for members of the public to request information, provide feedback and seek resolution to concerns related to quality of care. A Patient Care Quality Office was established in each health authority, replacing the former

Client Relations structure. An independent Patient Care Quality Review Board was also established to investigate concerns not addressed to the complainant's satisfaction by the health authority. Fraser Health's Patient Care Quality Office is responsible for coordinating follow up of requests for information and complaints from Fraser Health patients, residents and clients. The Patient Care Quality Office can be contacted via telephone, e-mail or in person, with information provided via the Ministry of Health, Fraser Health's public website, and brochures available within sites across the organization.

Significant effort is underway on an ongoing basis to engage patients and families in care planning and system improvement. In April, 2011 a Patient Advisory Council was established to provide guidance and stewardship of Fraser Health's focus on building and strengthening patient/provider partnerships. The Patient Advisory Council's vision is "We are all in this together" — in essence promoting shared ownership for creating health care excellence. Patient Advisors are involved in a number of high-priority initiatives, such as the 'Seamless Care" strategy, designed to coordinate and improve the patient's journey across the continuum of care, a "Patient Safety Briefings" initiative, designed to engage patients in promoting a safe experience while in care and sharing their improvement ideas, and the development of patient education materials. The Patient Advisory Council has developed an annual work plan that is focused on building capacity for patient engagement and partnership at the clinical program level to ensure the patient's experience is at the centre of all improvement activities.

17. "The Fraser Health Authority is working to establish a Hospitalist Program at all acute sites in the region. A hospitalist is a physician who is contracted by the hospital to act not only as a provider of care, but as a coordinator of care throughout the patient's stay. They work with the patient, family, nursing staff and specialists, providing timely, efficient and effective care. With hospitalists on site, physician response time for assessing the patient and beginning diagnostic work-up is significantly reduced. The availability allows for timely reevaluation of the patient as well as greater communication between the hospitalist and other professional care providers resulting in improved continuity of care for each patient. At CGH, participants in the hospital's residency program will link with the hospitalists."

In 2002 the Hospitalist service was just getting underway in Fraser Health. It has since evolved at a number of acute care sites to assume the role of the Most Responsible Physician for in-hospital medical care. Other sites, including CGH, have retained the family practitioner model with the support of Ministry of Health funding to enhance the family practitioner's presence in the hospital setting (e.g., daily rounds, phone consultations). This model promotes coordination and continuity of care for patients by their own family physicians throughout their hospital stay and as they transition between hospital and the community.

18. "The FHA is working hard to build a patient-focused culture across the organization by supporting our front-line care providers. One tangible example of this is the new role of the Patient Care Coordinators who provide nursing staff with on-site clinical leadership. We have developed a policy and protocol for interdisciplinary working relationships to identify and resolve communication issues, and are holding educational sessions about this policy."

Fraser Health's Professional Practice and Integration team continues to promote the critical role of a healthy practice environment in the provision of quality care. The elements of healthy practice environments focus on shared purpose, dialogue, relationships, scope of practice, competency, hand-offs, evidence based practice and integrated documentation. This is built into the practice council network orientation for all staff and should be the platform for interprofessional practice discussions. The Patient Care Coordinator job description and role competencies have been standardized across acute care; orientation and education have been developed and implemented to support this role. Ongoing feedback from Patient Care Coordinators, Managers and Site Leaders is continuing to inform the development of this education. Work is also underway to standardize the role and supports for Managers and Site Leaders.

19. "Under the direction of Dr. Robert Halpenny, we are working to standardize advance directives and DNR policy and procedures across the Fraser Health Authority, which meets best practices in the industry. A significant component of the process will be based on communication between health care providers, patients and families. It is anticipated that the initiative will be completed in 2003. The importance of clear, readily understood information for families, and for education and monitoring, will be a strong focus of this work."

Over the past ten years Fraser Health has championed the development, implementation, evaluation and dissemination of various activities related to Advance Care Planning (ACP) and Do Not Resuscitate (DNR) including:

- Formation of an ACP Steering Committee (2004)
- Staff training and education (2005) by Respecting Choices© faculty from the Institute of Health Improvement best practice initiative.
- Implementation of the Fraser Health regional DNR for all acute sites (2005). The new DNR form includes documentation regarding the process by which the decision has been made (who the physician has spoken with) and the scope of treatment (comfort or medical therapy including or excluding critical care). Fraser Health also implemented a standardized communication system to promote clear communication on the patient's health record regarding treatment options to alert health care providers in the event of respiratory and/or cardiac arrest and ensure their response aligns with the patient's expressed wishes.
- Development of a number of tools and resources that are available to health care professionals/providers as well as the public in several languages on the Fraser Health website. (<a href="http://www.fraserhealth.ca/your care/planning for your care/">http://www.fraserhealth.ca/your care/planning for your care/</a>): My Voice Workbook©; Making Informed Decisions About CPR brochure; Information Booklet about ACP; Planning in Advance for Your Future Healthcare Choices (e-book); Information DVDs; and posters. There is also a toll- free telephone number (1-877-TALK-034), public email address (<a href="mailto:advancecareplanning@fraserhealth.ca">advancecareplanning@fraserhealth.ca</a>), and ongoing education for health care professionals. To date, more than 2000 health care professionals have attended Advance Care Planning education. Information about advance care planning is also provided in the regional on-line staff orientation sessions as well as at the program/site level.
- Launch of the "Making the MOST of Conversations" strategic initiative across all clinical programs to engage patients and their families in conversations to improve decisionmaking and advance care planning (2010). In October 2012 a new policy and form

(Medical Orders for Scope of Treatment or MOST form) were implemented that combined and replaced the Levels of Intervention form from residential care and the acute care DNR. Fraser Health continues to work on tools and resources to help care providers initiate and track advance care planning conversations and translate them into a clear plan of care and medical orders in collaboration with patients and their families. This work has been recognized by a BC Patient Safety and Quality Council Award for Excellence in Quality and Patient Safety in the category of *Coping with End of Life* (2010).

20. "It is our responsibility to provide safe levels of staffing. The involvement of family is welcomed. Our least restraint policy and falls prevention strategy, to be implemented across FHA, both highlight the need to inform and involve family. New, soft cloth magnetic restraints, now in use, allow for greater patient mobility when restraints are indicated."

Approved restraints are identified in the Least Restraint Policy, and only these are authorized to be used. Please see #3 above.

21. "This is an area where we recognize the need to continue working, if we are to make family involvement part of the culture, and of our expectations of nursing leadership."

Fraser Health participates in the provincial Patients as Partners committee and on the Board of the Patient Voices Network to ensure patients and families voices are heard, valued and acted on. The Fraser Health Patient Advisory Committee is recognized by the Fraser Health Board, Executive and clinical programs for its role in working with clinical and administrative leaders to bring the patient's perspective to all priority improvement initiatives.

22. "This underlies the importance of assessment, e.g. monitoring intake of fluids and food. We are continuing to work on this area and seeking significant improvements as our Food and Nutrition Services leadership works closely with clinical staff."

48/6 (see #9 above) is a provincial mandate which includes Nutrition/Hydration as a functional area.

Fraser Health is committed to providing safe, quality health care and service, and I very much appreciate your ongoing efforts to work with the health care system to improve care for the elderly. It is uncommon for a family such as yours who has been so negatively impacted by their loved one's care experience to be as willing to share their experience for the purpose of learning and improvement. Esther's Voice continues to generate conversations within our leadership about the importance of keeping the patient and family at the centre of everything we do. Your recent letter serves as a yet another important reminder to our leadership that we must be relentless in our pursuit of improving the quality and safety of care for the elderly.

We trust the responses above are helpful in resolving your concerns, and invite you to direct any further questions or concerns you may have regarding this update to Ms. Cathy Weir, Director, Quality Improvement and Patient Safety.

Sincerely,

Dr. Nigel Murray

President and Chief Executive Officer

NJM/tls

Cc:

David Mitchell, Chair, Board of Directors Dr. Andrew Webb, Vice President, Medicine Cathy Weir, Director, Quality Improvement and Patient Safety

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## TOTAL HIP/ KNEE REPLACEMENT CAREPATH Day 0 - Operative Day-After Surgery Regional Surgical Program

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### TOTAL HIP/KNEE REPLACEMENT CAREPATH Day 0 - Operative Day-After Surgery Cont'd Regional Surgical Program

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### TOTAL HIP/KNEE REPLACEMENT CAREPATH Day 0 -Operative Day-After Surgery Cont'd **Regional Surgical Program**

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PWXX102920D Rev: May 11/10 Page: 3 of 6 INTAKE D OUTPUT D Amount Start Time IV Solutions, Amount, Meds Added Time Urine Absorbed Fluid Replacment: OR/PACU: Urine: EBL: 08 09 10 11 12 13 FLUID BALANCE / ELI M I NATION 15 16 17 18 19 12 HR **12 HR** Start Time INTAKE N **OUTPUT N** 20 21 22 23 24 01 03 04 05 06 12 HR 12 HR 24 HR Total INTAKE: 24 HR Total OUTPUT: Today's 24 hr Balance: + / -IV Site \_\_\_\_ satisfactory. D\_\_\_ E\_\_ N\_\_ Maintain CA-UTI Prevention Strategies If symptomatic for UTI send C&S and notify MRP Foley removed at 0600 N Specify reason if foley left in: \_\_\_\_ Asymptomatic for UTI D \_\_\_\_ E \_\_\_ N\_\_\_ Output > 120 mL / 4 hrs D \_\_\_\_ E\_\_\_ N\_\_\_ Last BM Date: ANEMIA Pre-op Hgb \_\_\_\_\_ Asymptomatic for anemia D \_\_\_\_ E \_\_\_ N\_\_

E. LEESING TEMPERATURES AND REPORT OF THE PROPERTY OF THE PROP

## TOTAL HIP/KNEE REPLACEMENT CAREPATH Day 0 - Operative Day - After Surgery Cont'd Regional Surgical Program

CARE	FOCUS			OUTCO	DMES in Bold		
N	Administe	r anti-emet	tic regularly if naus	ea or vomiting.			
NUTRITION			Tolerating di	et. 🛚 Regular	☐ Other		D
H H					No nausea or vomiting. D		
N			Patient sta	ates nausea unde	er control with anti-emetic. D	E	_ N
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R N					Expected length of stay	reinforced	. D
HN			Verify LMW	H coverage form	faxed to Ministry of Health (if a	pplicable)	. D
DISCHARGE PLANNING	_			Support per	son available x 48 - 72 hrs post	discharge	e. D
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### TOTAL HIP/KNEE REPLACEMENT CAREPATH Day 0 - Operative Day After Surgery Cont'd Regional Surgical Program



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## TOTAL HIP/KNEE REPLACEMENT CAREPATH Day 0 - Operative Day After Surgery Cont'd Regional Surgical Program

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	If sympto	omatic for UTI send C&S and	notify	MRP						
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Ź				No	evidence	of blee	ding d/t	LMWH.	DE	N
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NUTRITION	Administer anti-emetic regularly if nausea or vomiting.  Tolerating diet. □ Regular □ Other◆ D	
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TR	No nausea or vomiting. D E N	
I I	Patient states nausea under control with anti-emetic. DEN	<u> </u>
SKIN	Turn q2h. Change dressing if ordered.  Wound approximated, clean, minimal or no clear drainage . ◆ D  Dressing dry and intact. D E N  Skin integrity maintained. D E N	
	WB Status:	
	Bed knee gatch turned off.  Sitting tolerance: min/hrs  Encourage cryotherapy 3x/day x 15min (if sensation satisfactory) as per physiotherapy	
	□ No signs of hip dislocation (sudden, sharp, severe pain, maialignment) ◆ □ □ □ □	N N
MOBILITY	Physiotherapy to complete:  □ PT Initial Assessment completed □ Written home excercise program provided and initiated • lying to sitting assist / sitting to lying assist • sitting to standing assist • Ambulation: assist aid meters □ Mobility impaired by: □ Nausea □ Vomitting □ Dizziness □ Pain □ Other:	HORALI PORT
	Mobility safe for discharge ◆ PT	
FUNCTION	Occupational Therapy to complete:    IND   STAND-BY   ASSIST   Equipment needed:   Toilet Transfer	P
J.F	Grooming  Patient / family participated in mobility and ADLs as per care plan. OT  Precautions maintained throughout ADL assessment and practice. OT	





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NNING	Dischar

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PLANNING	Discharge teaching:  LMWH subcutaneous injection reviewed  Wound / incision care  Post-op complications (DVT infections, anemia, constipation)  Pain management at home  Methods to prevent / decrease edema
DISCHARGE	Patient has acquired recommended ADL equipment. (OT) Patient has acquired recommended mobility equipment. (PT) Outpatient physiotherapy set up and information provided. (PT) Patient verbalizes understanding of discharge teaching. D No concerns regarding support at home for meeting target discharge date. D

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)
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TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)
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Screen for Delirium using CAMI at 1600, and PRN (Check boxes that apply) Delirious if both 1 and 2 and either 3 or 4 checked 3. Inattention □ 1. Acute onset and fluctuating course 4. Altered level of consciousness □ 2. Disorganized thinking □ Screen for, and address potential causes of delirium using PRISM - E (pain, retention, restraint, infection, impaction, sensory, meds, alcohol, metabolic-hypoxia, malnutrition, fluids and lytes, environment, hx of dementia) If delirium present and/or cognitive impairment; Encourage patient family/ care providers to stay Oriented X 3 (Time, person, place, age) D\_\_\_\_ E\_\_\_ N\_\_ CAMI negative D\_\_\_\_ E\_\_\_ N\_\_\_ Family/care provider state that patients cognition is at baseline D\_\_\_\_ E\_\_\_ N\_\_ Slept: ☐ well ☐ on/off ☐ poorly CWMS within patient's normal limits D E N DV Edema 2 or less, no calf redness or pain along vein D\_ **ANEMIA** Hgb . MD notified if < 90 or \_\_\_\_ if symptomatic or platelets < 100,000. Asymptomatic for anemia ◆ D \_\_\_\_ E\_\_\_ N\_\_ No evidence of bleeding d/t LMWH. D \_\_\_\_ E\_\_\_ N\_\_\_ NUTRITION ◆ D Tolerating diet. ☐ Regular ☐ Other\_\_\_\_ No nausea or vomiting. D \_\_\_\_ E \_\_\_ N\_\_\_ -OR-Patient states nausea under control with anti-emetic. D\_\_\_\_\_ E\_\_\_\_ N\_\_\_ NTEGRITY Change dressing if ordered. Wound approximated, clean, minimal or no clear drainage. D \_\_\_\_ SKIN Dressing dry and intact. D \_\_\_\_ E\_\_\_ N\_\_\_\_ Skin integrity maintained. D \_\_\_\_ E\_\_\_ N\_\_\_ ☐ PWB ☐ FeWB ☐ NWB WB Status: ☐ WBAT Reinforce with patient: ☐ Hip Precautions ☐ Other Precautions: \_\_\_\_ Nursing to complete: Encourage up to commode/washroom. Bed knee gatch turned off. Sitting tolerance: \_\_\_\_\_ min/hrs Encourage cryotherapy 3x/day x 15min (if sensation satisfactory) as per physiotherapy Up in chair for all meals. Tolerated well. D ☐ No signs of hip dislocation (sudden, sharp, severe pain, malalignment)◆ D\_\_\_\_ E\_\_\_ Universal fall precautions in place D Physiotherapy to complete: MOBILITY Written home exercise program reviewed. Pt. demonstrates satisfactory technique. lying to sitting \_\_\_\_\_ assist / sitting to lying \_\_\_\_ assist sitting to standing \_\_\_\_\_ assist ☐ Mobility impaired by: ☐ Nausea ☐ Pain ☐ Other ☐ Knee ROM ☐ Cryotherapy x 15 min. Sensation satisfactory. PT Stair Assessment \_\_\_\_ Recommended mobility equipment discussed with patient. PT Mobility safe for discharge ◆ PT





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Page: 4 of 6

CARE	FOCUS			0	UTCOMES in Bold					
		IND	STAND-BY	<u>ASSIST</u>	Equipment needed:					
z	Toilet Transfer									
	Shower/Tub Transfer									
은	Dressing									
<u> </u>	Grooming									
FUNCTION					Self-care practice opportunity provided. OT					
ш.		☐ Patient / family participated in mobility and ADLs as per care plan. OT								
			Precautions m	aintained tl	nroughout ADL assessment and practice. OT					
PLANNING	☐ Wound / inci ☐ Post-op com ☐ Pain manag	utaneou ision car iplication ement a	ns (DVT infection t home decrease eder	ons, anemia, ma						
DISCHARGE	Patient has acquired recommended ADL equipment. (OT)  Patient has acquired recommended mobility equipment. (PT)  Outpatient physiotherapy set up and information provided. (PT)									
DISCH	Patient verbalizes understanding of discharge teaching. D  No concerns regarding support at home for meeting target discharge date. D  Expected length of stay reinforced. D									

### VARIANCE NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)
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	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)
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	Screen for Delirium using CAMI at 1600, and PRN Delirious if both 1 and 2 and either 3 or 4 checked	(Check boxes that apply)	
	Acute onset and fluctuating course □	3. Inattention □	
	2. Disorganized thinking □	4. Altered level of consciousness □	
ELIRIUM	Screen for, and address potential causes of delirium timpaction, sensory, meds, alcohol, metabolic-hypoxia dementia)  If delirium present and/or cognitive impairment; Encou	, malnutrition, fluids and lytes, environment, hx of	n,
DELI		d X 3 (Time, person, place, age) D E CAMI negative D E	_ N
	Family/care provider state that	patients cognition is at baseline D E	_ N
		Slept: ☐ well ☐ on/off ☐ poorly	/ N
-	CW	MS within patient's normal limits D E_	N
DVT	Edema 2 or less, n	o calf redness or pain along vein D E_	N
¥	Hgb MD notified if < 90 or if sympton		
ANEMIA		Asymptomatic for anemia ◆ D E	
		o evidence of bleeding d/t LMWH. D E_	
NO	Tolerating diet. ☐ Regular	□ Other ♦ D	11/2
NUTRITION		No nausea or vomiting. D E	3 18 1
5	Patient states naus	ea under control with anti-emetic. D E	N
	Change dressing if ordered.		1 5
SKIN	Wound approximated, cl	ean, minimal or no clear drainage. D	1 6
SE E		Dressing dry and intact. D E	
Z		Skin integrity maintained. D E_	N
	WB Status: ☐ WBAT ☐ PWB ☐ FeWB ☐ Reinforce with patient: ☐ Hip Precautions ☐ Other Precautions:		
	Nursing to complete:		
	Encourage ambulation Bed knee gatch turned off.		
	Sitting tolerance: min/hrs		
	Encourage cryotherapy 3x/day x 15min (if sensation	satisfactory) as per physiotherapy chair for all meals. Tolerated well. D	
		harp, severe pain, malalignment)◆ D E Universal fall precautions in place D E	
>	Physiotherapy to complete:	Market - Committee	''
	Written home exercise program reviewed. Pt. demons		
MOBILITY	<ul><li>lying to sitting assist / sitting to lying _</li><li>sitting to standing assist</li></ul>	assist	
×	Ambulation: assist aid relation.	meters	
	☐ Mobility impaired by: ☐ Nausea ☐ Von		
+-	☐ Other	nacional de la companya de la compa	
	☐ Cryotherapy x 15 min. Sensation satisfactory.		DT
	Stair Assessment	ed mobility equipment discussed with patient.	PT
	neconmend	Mobility safe for discharge ◆	





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If no BM within past 72 hrs, advance bowel protocol to supps or enema.

Page: 4 of 6 STAND-BY IND **ASSIST** Equipment needed: **Toilet Transfer FUNCTION** Shower/Tub Transfer Dressing Grooming ☐ Self-care practice opportunity provided. OT ☐ Patient / family participated in mobility and ADLs as per care plan. OT ☐ Precautions maintained throughout ADL assessment and practice. OT ☐ Home care referral initiated: concerns related to wound care management or medications. ☐ LMWH prescriptions provided to patient. **DISCHARGE PLANNING** Discharge teaching continued and reinforced: ☐ Patient/family successfully demonstrates LMWH injection. Handout provided. ☐ Wound / incision care ☐ Post-op complications (DVT infections, anemia, constipation) ☐ Pain management at home ☐ Methods to prevent / decrease edema □ Preventing and managing constipation Patient has acquired recommended ADL equipment. OT\_ Patient has acquired recommended mobility equipment. PT\_ Outpatient physiotherapy set up and information provided. PT\_ Patient / family demonstrate LMWH administration. Kit provided. D\_ No concerns regarding support at home for meeting target discharge date. D If patient not prepared for discharge today or tomorrow, specify reason below. Mark the most significant reason with an asterisk (\*). DELAYED DISCHARGE □ delirium medical issues: □ wound related □ unmanaged pain ☐ nausea and vomiting; not tolerating diet anemia related concerns voiding difficulties mobility not satisfactory inadequate support at home patient cleared to go by team but reluctant to leave

#### NOTES

Explain:

Other:\_

□ awaiting transfer to another hospital

inadequate home environment for equipment set-up

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)
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	Screen for Delirium using CAMI at 1600, and PRN (Chaplerious if both 1 and 2 either 3 or 4 checked	neck boxes that apply)	รถะเกษที่ สารเกษที่
	1. Acute onset and fluctuating course □ 3.	Inattention □	urgu u Organ
	2. Disorganized thinking ☐ 4.	Altered level of consciousness	
ELIRIUM	Screen for, and address potential causes of delirium usin impaction, sensory, meds, alcohol, metabolic-hypoxia, m dementia) If delirium present and/or cognitive impairment; Encourage	alnutrition, fluids and lytes, environment, hx of	n,
DE	Oriented X	3 (Time, person, place, age) D E	_ N
	For the form and the state that we	CAMI negative D E	
	Family/care provider state that pa	tients cognition is at baseline D E Slept: □ well □ on/off □ poorly	
	OWNO		
DVT		within patient's normal limits D E	
		alf redness or pain along vein D E	N
ANEMIA	Hgb MD notified if < 90 or if symptomati		N.
New Year		Asymptomatic for anemia ◆ D E vidence of bleeding d/t LMWH. D E	
O	Tolerating diet. ☐ Regular ☐	Other ◆ D	
E		No nausea or vomiting. D E	N
NUTRITION	Patient states nausea	under control with anti-emetic. D E	N
	Change dressing if ordered.		- 5
SKIN INTEGRITY	Wound approximated, clear	n, minimal or no clear drainage. D	
SKIN		Dressing dry and intact. D E_	
Z		Skin integrity maintained. D E_	N
	WB Status: ☐ WBAT ☐ PWB ☐ FeWB ☐ NV Reinforce with patient: ☐ Hip Precautions ☐ Other Precautions:		
	Nursing to complete: Encourage ambulation Bed knee gatch turned off.		
	Sitting tolerance: min/hrs Encourage cryotherapy 3x/day x 15min (if sensation sati Up in cha  No signs of hip dislocation (sudden, shar	air for all meals. Tolerated well. D	N
	Ur	niversal fall precautions in place DE_	
≥	Physiotherapy to complete:	too esticiostory technique	
MOBILITY	Written home exercise program reviewed. Pt. demonstra  living to sitting assist / sitting to lying		
OB	sitting to standing assist		
Σ	Ambulation: assist aid met	ers	
	☐ Mobility impaired by: ☐ Nausea ☐ Vomitin	ng 🗆 Dizziness 🗆 Pain	
	Other		
	☐ Cryotherapy x 15 min. Sensation satisfactory.		
	☐ Stair Assessment		PT
	Recommended	mobility equipment discussed with patient.  Mobility safe for discharge	PT
		widding sale for discharge	





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Last BM Date:

If no BM within past 72 hrs, advance bowel protocol to supps or enema.

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	T	INTE	OTAND DV	ACCIOT	For the month pended!	11 - 15 11
	Toilet Transfer	<u>IND</u>	STAND-BY	<u>ASSIST</u> □	Equipment needed:	
Z	Shower/Tub Transfer				J150 and 69/44	
	Dressing				MC in 2 Greek	
FUNCTION	Grooming				Years with wine	
5	Citotiling				Self-care practice opportunity provided.	ОТ
		□ P	atient / family	participate	d in mobility and ADLs as per care plan.	OT
					roughout ADL assessment and practice.	от
				ated to woun	d care management or medications.	
ত্র	☐ LMWH prescription Discharge teaching co	is provid	ed to patient.	4.		
	☐ Patient/family	success	sfully demonst	rates LMWH	injection. Handout provided.	
Z	☐ Wound / incis	ion care				
7	☐ Post-op comp☐ Pain manage			ns, anemia,	constipation)	
<u> </u>	☐ Pain manage ☐ Methods to pr			ma		
5	☐ Preventing ar			ion	+	-
				Patient has	acquired recommended ADL equipment	. 01
₹			D. 1	' attent has	wined recommended mobility equipment	DT
СНА				ient has acc	quired recommended mobility equipment	. PT
DISCHA			Outpa	tient has acc	quired recommended mobility equipment otherapy set up and information provided	i. PT I. PT
DISCHARGE PLANNING	110		Outpa Patient / fai	tient has acc tient physic mily demons	quired recommended mobility equipment otherapy set up and information provided strate LMWH administration. Kit provided	t. PT I. PT d. D
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DISCHA	If patient not prepared	for discl	Outpa Patient / far erns regardin	tient has acc tient physio mily demona ng support a r tomorrow, s	quired recommended mobility equipment otherapy set up and information provided strate LMWH administration. Kit provided at home for meeting target discharge date	t. PT I. PT d. D
	If patient not prepared Mark the most signification	for discl	Outpa Patient / far erns regardin	tient has acc tient physio mily demona ng support a r tomorrow, s	quired recommended mobility equipment otherapy set up and information provided strate LMWH administration. Kit provided at home for meeting target discharge date	t. PT I. PT d. D
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## TOTAL HIP/KNEE REPLACEMENT CAREPATH

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