Complex Continuing Care – Restorative Care (Combined Functional Enhancement and Restorative Care Programs)

Description:
The Restorative Care program provides a moderate to low intensity goal-oriented rehabilitation program for adults who are unable to return after assessment in acute care or those individuals who meet eligibility criteria from the community. The length of stay is goal dependent and is up to 90 days as required to improve strength, endurance, or functioning to ensure a safe transition to the community. Care plans are individualized and will be adjusted according to the individual’s tolerance level. Occupational therapy and physiotherapy is limited (the model is based on the delivery of 15 minutes of therapy three days per week) within a therapeutic setting that includes nursing rehabilitation, a community dining room, and opportunities for socialization.

Examples of individuals who may benefit from this program include those who have specific and realistic functional goals following:

- an acute or prolonged illness that has left them de-conditioned
- an injury that requires a prescribed period of non-weight bearing followed by a period of rehabilitation
- surgery where post-operative complications have prolonged functional recovery

Examples of individuals who may not be as successful in this program include those who are:

- demonstrating acute delirium, unresolved episodes of confusion, or cognitive impairment which limits their ability to participate in goal setting and/or the program
- palliative with a prognosis of less than three months
- primarily requiring respite care

Guiding Principles for Admission:

- The referral source and the receiving service are responsible for ensuring that “the right patient is in the right bed, at the right time, with the right caregiver”.
- The referral source has first-hand knowledge of the patient and is responsible for identifying specific, measurable, timely, and realistic goals and barriers to discharge.
- The referral source is responsible for being knowledgeable of and consistently applying the referral criteria.
Determining Medical Stability – Restorative Care

- a clear diagnosis and co-morbidities have been established
- medical conditions are stable and can be managed within the scope of an RN/RPN and do not require daily reassessments by a physician. (Physicians round once per week. Physicians have 24 hour 7 day a week on call coverage but may not see a patient for up to 72 hours following admission.
- all abnormal lab values have been acknowledged and addressed as needed.
- all consults and diagnostic tests for the purposes of diagnosis or treatment of acute conditions have been completed and reported or pending test results are not anticipated to dramatically change the treatment plan. A follow-up plan is in place at the time of the referral and follow-up appointments have been made at the time of discharge from the acute hospital
- no acute psychiatric issues limiting the patients' ability to participate in the program

Determining if a patient is a candidate for the Restorative Care Program:

Admission Criteria:

- Individuals with minimum age of 18 years.
- The individual’s needs are unable to be met with community resources (community services, outpatient therapy, CCAC services, and private pay services). Applications from the community should have current CCAC involvement and have maximized community-based services.
- The individual is medically stable; all acute medical issues have been resolved or reached a plateau.
- The individual or their substitute decision maker (SDM) has agreed to participate in the program and the individual demonstrates commitment, willingness, and motivation to participate in the program. The individual/SDM understands the regional nature of the program and the participant’s letter of understanding has been completed.
- There is reason to believe that, based on clinical experience and evidence in the literature, the individual is likely to benefit from the program.
- The individual demonstrates the potential to attain the identified functional goals and has the ability to participate and integrate new learning and skills into daily life.
- Functional and/or clinical goals have been established and are specific, measurable, realistic, and timely
- The individual has demonstrated potential to tolerate being up in a chair 2-3 times per day.
- The individual demonstrates sufficient cognitive ability to participate in goal setting and carryover new learning into their activities of daily living. For example, where a patient scores 15/30 or less on a MOCA or a delayed recall of less than 2/5, they may not be able to achieve carryover of new skills.
- The individual/SDM is committed to returning to the community, utilizing family and community support services as required.
☐ A realistic and viable discharge plan is identifiable and has been discussed with the individual.

☐ The individual’s special equipment needs have been determined.

☐ The treatment of other co-morbid illnesses/conditions does not interfere with the individual’s ability to actively participate in the program on a daily basis (for example, ongoing chemotherapy, radiation therapy, and dialysis which require frequent trips off site and may impact activity tolerance).

**Exclusion Criteria**

☐ Those exhibiting violent behaviors with tendencies to harm self, others or property

☐ Unresolved delirium

☐ Acute psychiatric issues limiting the patient’s ability to participate in the program

☐ Exit-seeking behavior

☐ Individuals who have been assessed as palliative with a prognosis of less than three months

☐ In need of high-flow oxygen (> 4L/min) or humidified O2

July 25, 2012
**WATERLOO WELLINGTON REHABILITATION/TRANSITIONAL PROGRAM FRAMEWORK (07/09/12)**

**Medical Stability:**
- a clear diagnosis and co-morbidities have been established
- medical conditions are stable and can be managed within the scope of an RN/RPN and do not require daily reassessments by a physician
- all abnormal lab values have been acknowledged and addressed as needed.
- all consults and diagnostic tests for the purposes of diagnosis or treatment of acute conditions have been completed and reported or pending test results are not anticipated to dramatically change the treatment plan. A follow-up plan is in place at the time of the referral and follow-up appointments have been made at the time of discharge from the acute hospital
- no acute psychiatric issues limiting the patients’ ability to participate in the program.

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<tr>
<th>REHABILITATION SECTOR</th>
<th>COMPLEX CONTINUING CARE SECTOR</th>
<th>LONG TERM CARE SECTOR</th>
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<tr>
<td>Moderate to High Intensity Rehabilitation</td>
<td>Restorative Care (Moderate to Low Intensity Rehabilitation)</td>
<td>Low Intensity Rehabilitation</td>
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**Intensive** goal-oriented general rehab program for adults who require 60 minutes of therapy daily. **Average LOS** is goal dependant and is expected to range between 14 and 40 days

Available at CMH, SJHCG, GRH

**Moderate to Low intensity** goal-oriented rehab program for adults who are unable to return home after assessment in acute care or meet eligibility criteria from the community.

Philosophy of care is focused on rehabilitation and restoring function.

The Average LOS is goal dependent (up to 90 days) and focuses on improving strength, endurance, and/or functioning to ensure a safe transition to the community

Available at SJHCG, GRH and Groves (dependent on treatment plan and client needs)

**Low intensity** goal-oriented rehab program for deconditioned adults or seniors recovering from injury due to fall, surgery or an extended acute hospital admission.

A LTC therapeutic environment with access to consulting therapies serves to enhance the frail senior’s recovery over time.

**Average LOS** is goal dependent and will not exceed 90 days.

Available at Sunnyside.

RAI-HC must be completed prior to admission

**Therapeutic Criteria:**
Demonstrates **potential to tolerate** being up in a

**Therapeutic Criteria:**
Care plans are individualized and will adjust to the patient’s tolerance

**Therapeutic Criteria:**
Requires and is able to tolerate ≥ 1 hour of therapy daily

Achievement of functionally significant and consistent progress towards identified goals on a daily basis.

level. OT, PT is limited (based on the model of 15-30 minutes of therapy 3-5 days per week) within a therapeutic setting that includes nursing rehabilitation, a community dining room, and opportunities for socialization.

Demonstrates potential to tolerate being up in a chair 1-2 hours, 2-3 times/day.

Demonstrates achievement of functionally significant and consistent progress towards the identified goals on a weekly basis.

*Palliative clients with a longer life expectancy should be considered within the admission criteria as long their medical treatment plan does not limit participation in the therapy program.

*LTC patients who resided in LTC prior to admission should return to LTC to receive restorative care

Able to be up in a chair 1-2 hours, 2-3 times per day or willing to participate in a functional enhancement program to achieve up in chair time

Requires and is able to tolerate 15 minutes of therapy, 3 times per week

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<tr>
<th>Realistic Discharge Plan Initiated:</th>
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| Discharge dependant on goal attainment and/or functional plateau. Initiated discharge plan to the community (e.g. previous living arrangement such as: home, RH, supervised living, independent living) from sending site. | • Discharge is dependent on goal attainment and/or functional plateau.  
• A realistic and viable discharge plan the community (e.g. previous living arrangement such as: home, RH, supervised living, independent living) has been initiated and has been discussed with the individual.  
*Discharge planning from restorative care will follow the Home First Philosophy. |

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<th>Discharge Plan Established:</th>
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<td>Discharge dependent on goal attainment and/or functional plateau to a maximum of 90 days</td>
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Established discharge plan home or retirement home.

May be on the LTC waitlist with goal to return home to await placement. If a bed offer occurs client/SDM may accept and move to LTC.

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