

2012

Hospital Care for Seniors: 48/6 Approach



INTRODUCTION

The 48/6 Model of Care for hospitalized seniors (aged 70 and older) in BC is an integrated care initiative which addresses six care areas of functioning through patient screening and assessment (assessments are completed only where screening shows areas of concern). Screening and/or assessments are then supported by the development of an individualized care plan to address key areas of health for the senior. Care Plans must be developed within 48 hours of decision to admit and further supported by a discharge and/or transition plan to ensure the senior can return to home safely with established access to the health resources in the community they require.

WHY THIS IS IMPORTANT?

More seniors are living longer and, in doing so, are also living with chronic conditions. When such a person requires care for an acute condition, applying the 48/6 approach in hospital offers the senior the opportunity to counteract what might have previously been fatal, while not ignoring the impact of ongoing chronic conditions.

COST – “Take the time to save the time.”

Applying the 48/6 approach will require more clinician time upstream but the expected payback will be time saved to the individual and the overall system downstream. To help achieve effective and sustainable implementation of 48/6, educational tools to help clinicians work with seniors are also being developed.

DESCRIPTION

The focus of 48/6 is to screen and assess (within 48 hours of decision to admit) the following six care areas and, in collaboration with the senior (defined as a patient 70+ years of age), complete a care plan based on that assessment. The six care areas are:

1. Bowel and Bladder Management: working with the patient to maintain their usual bowel and bladder function, intervening where necessary with additional interventions.
2. Cognitive Functioning: refers to the mental processes including memory, thinking, judgement, calculation, and visuospatial skills. Attention must be paid to the possibility of delirium, depression, dementia, and mild cognitive impairment.
3. Functional Mobility: a person’s ability to stand, walk, and transfer from bed to a chair. Bed rest inhibits a person’s capability to perform these functions as it contributes to muscle atrophy and reduced endurance.
4. Medication Management: reviewing each person’s medication list, dosages (dose and dose interval), potential medication interactions and balancing the benefits versus the risks of medications.

48/6 Clinical Care Management

5. Nutrition and Hydration: ensuring adequate amount and type(s) of food and liquid consumed, assessing for any swallowing difficulties and/or food allergies, and supplementing intake, where necessary.
6. Pain Management: refers to the use of medications and other interventions (such as massage, exercise, or physiotherapy) to prevent, reduce, or stop acute or chronic pain.

These care areas have been shown to be interrelated. A clinician cannot focus on one or two alone because each one affects the other.

SCREENING AND ASSESSMENT PROCEDURE

STEP 1 - Within the first 48 hours of hospital admission:

- a) Use a standardized approach (i.e., screening and assessment tools validated in the literature or validated internally), screen all six care areas and further assess where a concern is indicated. Screening and/or assessments examine the senior's level of function in the six care areas to determine the senior's baseline status, reported changes over the past 14 days, and current state.
- b) All concerns in the six care areas noted during the assessment process must be documented in the care plan. If no concerns are identified in a care area, a note should be left on the care plan to indicate the same.

STEP 2 - Throughout the hospital stay:

Combining all information into one place allows the inter-professional health care team to develop a comprehensive and evidence informed individualized care plan based on clinical best practice. Daily assessments as well as planned or completed interventions should all be recorded as part of the Care Plan development. If anything changes in a patient's condition during their stay, interventions should be identified and the care plan updated accordingly.

STEP 3 – Establish communication needs in preparation for successful discharge:

Establish an effective and timely discharge and/or transition planning process. This includes a timely communication between hospital and home. "Home" is defined by the patients needs. A safe return home may need to be supported by community-based resources including the patient's Primary Care Practitioner(s), community-based rehabilitation resources, family members and primary caregivers, or a residential care facility. Effective Discharge and/or Transition Planning includes establishing systems for the transfer of information contained within the care plan and the discharge and/or transition plan to community based care providers or other resources the patient may need upon discharge. The goal is to ensure the patient has the information they need, established access to services, and a thorough understanding of what to expect, and where to get information upon discharge.

TRACKING OUR PROGRESS

The measures that will be used to track progress in 48/6 implementation are not yet finalized (approval from the Ministry is pending). However, the approach being recommended by the clinical expert group is to initially (Phase I) track six process measures to assess the success of the implementation of 48/6. Screening (and assessment of the care area(s), where the senior screens positive) must be completed in the first 48 hours of hospital admission and include the reported baseline status, reported changes over the past 14 days, and current state:

1. Percent of patients screened for **bowel and bladder function** using a standardized approach.*
2. Percent of patients screened for **cognitive changes** (including dementia, delirium, and depression) using a standardized approach.*
3. Percent of patients screened for **functional mobility** using a standardized approach.*
4. Percent of patients screened for **medication management** using a standardized approach.*
5. Percent of patients screened for **nutrition and hydration** using a standardized approach.*
6. Percent of patients screened for **pain** using a standardized approach.*

**See the Practice Statements below for further detail on each of these areas of care.*

Phase I measurement will provide a baseline of where effective screening and assessment is being completed. This will allow work units to celebrate the good work currently being done, and plan how to expand the 48/6 approach further, if necessary.

For Phase II, it is anticipated that these six process measures will be replaced with a bundled process measure. The bundled process measure that will be tracked to assess the success of the implementation of the Hospital Care for Seniors 48/6 Model of Care in Phase II of implementation is the development of an individualized Care Plan. This Care Plan must address the following:

- Screening of each of the six areas of care.
- In depth assessments conducted for any area of concern.
- Continual monitoring of all six areas of care to ensure that emerging conditions do not go unaddressed throughout the hospital stay.
- An individually targeted plan of care to address each area of concern and the interrelated aspects of each.

This process must be completed in the first 48 hours of hospital admission and include the reported baseline status, reported changes over the past 14 days, and current state. The indicator is:

- Percent of patients with **care plans** completed within 48 hours of admission to hospital.

Measure(s) of health outcomes resulting from this initiative are still in development and will be included in Phase II.

SUMMARY

The better a health care team does in terms of upfront screening and assessment, means the better chance a senior has of maintaining their baseline level of independence, returning home sooner and freeing up capacity in the system. Current assessments already address many, if not all, of the six care areas. However, more in-depth information on pre-hospital function and consistent documentation (i.e., the 48/6 approach) will allow good care to become great care.