Ontario
Waterloo Wellington Local Health Integration Network

SUNNYSIDE Seniors' Services
Region of Waterloo SOCIAL SERVICES

Convalescent Care Program – Sunnyside Home

Description:

The Convalescent Care Program provides a low intensity SMART goal – oriented rehabilitation program for adults who are unable to return home 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 (MOHLTC Guideline) as required to meet the client's goals for improved strength, endurance, or functioning to ensure safe transition to the community. Care plans are individualized and will be adjusted according to the individual's tolerance level. Physiotherapy is based on a model of delivery of 15-30 minutes of therapy 5 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 SMART goals related to ADLs 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.
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Examples of individuals who may not be 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.
- Moca < 15/30.
- Palliative with prognosis of less than three months.
- Primarily requiring respite care.
- Independent with ADLs

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 consistently applying the referral criteria.

Determining Medical Stability- Convalescent Care Program

- 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. (Physician rounds once or twice a week. Physicians have 24/7 week on call coverage but may not see a patient for up to 72 hours following admission.)
- All abnormal labs have been acknowledged and addressed as needed.
- All consults and diagnostic tests for the purpose 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.
- No behaviours that would interfere with compliance and participation in the program.

Determining if a patient is a candidate for Convalescent Care Program:

Admission Criteria:

- Meets eligibility criteria for admission to long-term care:
  - The person is at least 18 years old
  - The person is an insured person under the health Insurance Act
  - The person requires that nursing care is available on site 24 hours a day; requires at frequent intervals throughout the day, assistance with activities of living; or requires, at frequent intervals throughout the day, on-site supervision or on-site monitoring to ensure his or her safety or well-being
- The individual's needs are unable to be met with community resources (Community services, outpatient therapy, LHIN services). Application from the community should have current LHIN 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 has agreed to participate in the program and the individual demonstrates commitment, willingness, and motivation to participate in the program. The individual 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 Activity of Daily Living (ADL) goals and has the ability to participate and integrate new learning and skills into daily life.
- ADL goals have been established and are specific, measureable, realistic, and timely.

- The individual has demonstrated potential to tolerate being up in a chair for 2-3 times per day, or is willing to achieve this goal.
- The individual demonstrates sufficient cognitive ability to participate in goal setting and carry over new learning into their activities of daily living.
- The individual 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 and communicated prior to admission.
- The treatment of other co-morbid illness/conditions does not interfere with individual's ability to actively participate in the program on a daily basis (for example, ongoing chemotherapy, radiation therapy, and dialysis which requires frequent trips off site and may impact activity tolerance).

Exclusion Criteria:

- Exhibiting violent behaviours with tendencies to harm self, others or property
- Unresolved delirium
- MOCA 15/30 or less or a delayed recall of less than 2/5
- Acute psychiatric issues limiting the patient's ability to participate in the program.
- Exit-seeking behaviour
- Individuals who have been assessed as palliative with a prognosis of less than three months.
- In need of high flow oxygen greater than 4L/min.
- IV/PICC Line
- Tracheotomy
- Feeding Tube
- Peritoneal Dialysis
- Abdominal and Chest Tubes
- Complex wound care or over Stage 2/VAC Therapy
- TPN