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Ontario Shores- Brief History
Veterans Rehabilitation Hospital
1917 – 1919 WW1

Ontario Hospital 1917
History of Ontario Shores

• Built in 1913 as a psychiatric hospital
• 16 cottages each housing 70 patients
• A village like setting to give a home feeling of 400 acres with a working farm
• Used as a rehab hospital during WW1
• Reopened as the Ontario Hospital for the Insane post war with 1542 beds
• In 1968 renamed Whitby Psychiatric Hospital
Ontario Shores Today

- Rebuilt in 1993, opened in 1996 as a state of the art mental health facility
- The first built in Canada in over 25 years
- 8 interconnected buildings, covering 483,000 square feet with accessible outdoor courtyards linked by a 1400 foot corridor
- Renamed Ontario Shores Centre for Mental Health Sciences in 2009
- Currently 325 beds; Average length of stay 147 days
Background: Our Patients

- Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a public hospital providing a spectrum of specialized assessment and treatment services to those living with complex and serious mental illness
  - Long term care facilities
  - Acute Care Hospitals
  - Home/ Group Homes/Shelters
  - Courts/ Correctional Facilities
Dementia

• “Dementia is a syndrome consisting of a number of symptoms that include loss of memory, judgement and reasoning, and changes in mood and behaviour.”

• Canadian Alzheimer Society, 2006
The Geriatric Dementia Unit is a 23 bed unit where all patients with a form of dementia are treated.

It is geriatric and dementia friendly.

We use pharmacological and non-pharmacological treatments to help improve the quality of life and decrease agitation and aggression in the person with dementia.
Stages of Dementia

• Early stage: Gradual onset often go unnoticed. eg. forgetful, losing track of time, lost in familiar places

• Middle stage: Symptoms become clearer & more restricting. eg. forgetting peoples names difficulty with communications, behavioural changes, needing assistance with personal care.

• Late stage: Total dependence and inactivity. eg. Unaware of time, difficulty walking, behaviour changes may escalate become aggressive.
Admission Challenges

- Can be poor historians
- Unknown history (i.e. tuberculosis, AROs..)
- Consent from Substitute Decision Makers for vaccinations and tests that need to be done
- Collecting ARO screening specimens:
  - High acuity of mental illness, uncooperative, psychotic
  - Access to lab services (only 7-3 Monday-Friday)
  - Too agitated to take screening when first admitted
Challenges

Admission:
• Increase aggression
• Behavior change
• Medication Review
• R/O Delirium

Patients: Psychotropic medications i.e. mask disease and cause delay in treatment, affect WBC counts
• Inpatients may attend groups together
• Wandering/Invasive into each others space
• Poor hygiene/incontinent
The Patient Environment Risks

- Mobile population
- Longer length of stay
- Congregate in events or groups
- Recreational Therapy groups
- Sharing items (sensory items-cats, dolls)
- Patient can be intrusive.
- Dementia population needs to be directed

Difficulty following directions and understanding need for infection control.
Risk for implementation of precautions

We Know:

• Patient will not stay in room
  • Added Precautions /Isolation - You can’t lock the door – it’s against the law
  • Restraints – unintended consequences
    • – risk of pneumonia , skin damage or death
  Decompensation and deconditioning
• One to one care a sitter – expensive and difficult to maintain
• Let them go - risk
  – Balancing the care of one patient with the risk of others can be a challenge.
Precautions: Contact or droplet or Modified

• Goal- reduce risk of transmission –patient not in room
How?
• Broda chair to reduce patient movements if invasive.
• Extra cleaning especially horizontal surfaces
• Assisting / doing hourly patient hand hygiene
• Cohort symptomatic patients for meals and leisure time
• Cover any wounds especially MRSA .
• Spatial isolation keeping distance between pts.
• Is patient able wear a procedure mask?
• One piece jump suit
What we do..

• Assess every patient on a case by case basis

• Do a Risk Assessment: 4 C’s Cognitive, cooperative, contained, clean.

• Modify Precautions as required i.e. allow a patient out of his/her room providing
  • All secretions and excretions contained
  • Hand hygiene
  • Showered (personal hygiene)
  • Clothes clean
  • Cooperative or can be directed

• Spatial isolation

• Broda chair

• Jumpsuits or one piece clothing with zipper in back
Surveillance
Syndromic Surveillance 11 am daily

- To increase staff awareness of the importance of the physical assessment of the patient.
- Launched February 2008
- Tool includes:
  - Vitals done (symptomatic patients)
  - Visible assessment of the patient unwilling/unable to respond
  - Includes GI symptoms, upper respiratory symptoms
  - Prompts staff to initiate and take note of symptoms with all patients
- Meditech electronic system populates to IP&C alert list if patient has a yes on the list. eg. chills.
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolation Precaution</td>
<td>Droplet/contact</td>
</tr>
<tr>
<td>Chills or feels feverish</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes when was onset - Date</td>
<td>08/04/15</td>
</tr>
<tr>
<td>Cough (new or worse)</td>
<td>No</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>No</td>
</tr>
<tr>
<td>Headache</td>
<td>No</td>
</tr>
<tr>
<td>Myalgia (Muscle Pain)</td>
<td>No</td>
</tr>
<tr>
<td>Rash</td>
<td>No</td>
</tr>
<tr>
<td>Vomiting</td>
<td>No</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>No</td>
</tr>
<tr>
<td>Nausea</td>
<td>No</td>
</tr>
<tr>
<td>Temperature</td>
<td>38.5°C</td>
</tr>
</tbody>
</table>

Alert: Client is positive for at least one symptom of febrile respiratory illness.
Staff Timely Observations

• Physical assessment and vitals on admission, for 48 hours post admission and then weekly
• Increase vital signs if symptoms indicate.
• Change in physical symptoms noted quickly
• Decreased appetite, weakness, irritability
• Other vague signs indicating illness flushed face, diaphoresis, lethargy and personality change.
• Staff report changes on Syndromic FRI/Enteric IP&C alert list
Team effort to detect and contain

- Collect information regarding patients from many sources: cleaning staff, doctors, security, rec therapy, family, and nurses.
- Patients can rarely tell staff they do not feel well.
Cluster to outbreak?

- Baseline 3, 4 patients could be an outbreak.
- Vague symptoms: poor appetite, hoarse voice (if verbal), behavior changes, aggressive or combative.
- Sure sign: appear flushed in the face, T 37.8 or above.
- Sometimes, housekeeper notices increased symptoms before health care worker.
- Recreation or Occupational therapist may notice a change.
Cluster/Outbreak

- Precautions in patient’s room cannot always be followed due to patients who may wander.
- Patients are placed in broda chairs if restless and wandering unit.
- Placed just outside room helps to reduce agitation able to see activity.
- Staff do enhanced equipment cleaning of chairs.
- Enhanced H.H. for whole unit.
Cluster/Outbreak

If a cluster of respiratory symptom patients IP&C initiates temps BID on all patients. If symptoms progress place in added precautions then symptomatic patients temp. is taken every 4 hours and non symptomatic remain BID.

Precaution rooms cleaned every day with increased horizontal cleaning on the unit.

Activities such as doll and animal stimulation devices are taken off the unit unless they are washable.

Enhanced H.H. for whole unit.
Challenges & Strategies

Challenges
• Containing patients in room-broda chairs
• Unknown for patient as to what is going on
• Inability to verbalize
• Require more 1:1 staff time.
• Staff must pick up ALL symptoms. Visual, behavioral, measurable and personality changes (An art and a science)

Strategies
• Music played throughout unit.
• Positive reinforcement
• Keep family informed as family feedback and input invaluable with pt. changes
Key consideration

- Acute observation.
- Monitoring temperatures on all unit patients if cluster of respiratory symptoms.
- Contain ill patients
- H.H. enhanced
- Reduce transmission
- Team Work!
Questions ?
References

- World Health Organization: Dementia Fact sheet April 2016
- Routine Practices and Additional Precautions: In All Health Care Settings 3rd edition: Provincial Diseases Advisory Committee (PIDAC), November 2012