

Campbellford Memorial Hospital Hosts Seniors Appreciation Day June 19, 2015

News:

Campbellford Memorial Hospital hosted a Seniors Appreciation Day on June 19, 2015 from 10:00 a.m. until 2:00 p.m. The hospital invited a variety of community partners and service providers to share information and host demonstrations of interest to area seniors and their caregivers. A variety of professionals and community partners were on-site including:

- Community Care Access Centre
- Community Care
- Closing the Gap
- GAIN Team
- Campbellford Memorial Multi-Care Lodge
- Caressant Care Retirement
- Maple View Retirement Residence
- Ashley Tinney-Fischer -- Lawyer

Experts also spoke to seniors about medication management, diet and nutrition, falls prevention, the importance of immunization, and blood sugar testing.

In June each year, Ontario celebrates seniors and recognizes the contributions they make to our community. June 2015 marks the 31st annual Seniors' Month and this year's theme is Vibrant Seniors, Vibrant Communities.

QUOTES:

"We are focused on making Campbellford Memorial Hospital a senior friendly hospital and we have considerable experience delivering care to older adults. Our Seniors Appreciation Day was a great opportunity to partner with other community agencies and individuals to encourage wellness and prevention for seniors and their caregivers." Brad Hilker, President and CEO, Campbellford Memorial Hospital

QUICK FACTS:

Campbellford Memorial Hospital is one of nine hospitals in the Central East LHIN working
together to improve the health and well-being, as well as the care experience, of seniors while
in the hospital as part of a Senior Friendly Initiatives project of Seniors Care Network. Care
seniors receive while in a hospital, and the hospital experience itself, can impact their health
and well-being. The Working Group is focused on improving seniors' health and well-being by



taking steps to reduce the possibility of physical and mental decline while receiving care in hospital. A senior friendly hospital is one in which the environment, organizational culture, and ways of care-giving accommodate and respond to seniors' physical and cognitive needs, promote good health (e.g. nutrition and functional activity), maximize safety (e.g. preventing adverse events like a fall), and involve patients – along with families and caregivers – to be full participants in their care. The aim is to enable seniors to maintain optimal health while they are hospitalized so that they can return home or transition to the next level of care that best meets their needs.

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- Campbellford Memorial Hospital uses assessment tools like the Barthel Tool for Functional Decline to ensure elderly patients at risk of falling get the most appropriate care.
- The hospital serves as a community hub and referral to Geriatric Assessment and Intervention Network (GAIN). A program of Seniors Care Network, GAIN teams provide specialized care to support frail older adults living at home, including retirement residences with multiple complex medical problems including cognitive impairment, decreased function, falls or risk of falls, impaired mobility, incontinence and /or multiple medications. Frail older adults experiencing changes in support needs, safety concerns, psychological and mental health concerns or frequent health service usage will benefit from the services offered by their local GAIN team.
- CMH launched its Restorative Care program in 2012, thanks to funding received from the
 Central East LHIN in 2011. Our Assess and Restore Program includes specially trained nurses,
 physiotherapists, and a recreational therapist. The hospital is partnering with Central East
 Community Care Access Centre and Community Care Northumberland to ensure that patients
 are linked to services in the community to support their return home.
- CMH is a participant in the Home First initiative. Home First is a proven and effective model of care that is being delivered in hospitals across Ontario. Studies have shown that extended periods of time in hospital can have significant negative consequences on patients. The primary objective for the successful implementation of the Home First philosophy is to create conditions which allow patients to be returned to their community. Our Discharge Team includes a pharmacist, dietician, Community Care Access Centre representative, and a physiotherapist to ensure patients and their families have the documents and support they need including medication management, dietary counseling, community support and daily activity to transition safely from hospital to home and reduce hospital readmission. Early engagement ensures that the patient and family will have the best opportunity to be active participants in the discharge planning process.

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