

The Lunch Bunch: An Innovative Strategy to Combat Depression and Delirium through Socialization in Elderly Sub-Acute Medicine Patients

Margot Feyerer, BSc, MDiv
Interfaith Chaplain

Dawn Kruk, RN
Nursing Leader, Sub-Acute Medicine/Palliative Care Unit

Nicole Bartlett, RPN
Staff Nurse, Sub-Acute Medicine/Palliative Care Unit

Kathy Rodney, RN
Staff Nurse, Sub-Acute Medicine/Palliative Care Unit

Cyndi McKenzie, BSc, PT
Physiotherapist

Patrice Green, OTA/PTA
Physiotherapist Assistant

Lisa Keller
Communications Clerk, Sub-Acute Medicine/Palliative Care Unit

Pat Adcroft
Communications Clerk, Sub-Acute Medicine/Palliative Care Unit
London Health Sciences Centre – University Hospital

Abstract

Hospitalized sub-acute medicine patients face challenges to their functional and cognitive abilities as they await transfer to long-term care facilities or return home. The Continuous Quality Improvement (CQI) Council, representing a multidisciplinary team of healthcare professionals working in the Sub-Acute Medicine Unit (SAMU), implemented a twice-weekly lunch program called the Lunch Bunch in order to combat depression and delirium in our elderly and cognitively impaired patients.

The Lunch Bunch initiative includes chaplains, nurses and physiotherapists who have provided a framework through which essential socialization and exercise for this vulnerable population is facilitated. Providing a means for both mental and physical stimulation also allows patients to open up and discuss hidden feelings of loneliness and isolation, thereby beginning a journey of spiritual and emotional healing.

Introduction

Although acute care hospitals provide vital medical services, they are not properly equipped to offer the specialized care required by elderly persons. The elderly patient may have mobility, hearing and vision, or cognitive deficits, or some combination of these, that further complicate their care. They may be dealing emotionally and spiritually with the transition from healthy independence to a more limited lifestyle marked by dependence and possible institutionalization. Without consistent access to resources such as occupational therapy (OT) and physiotherapy (PT) that promote regular exercise and spiritual care for conversations about meaning and purpose, the elderly patient becomes more socially, spiritually and emotionally detached. Furthermore, the socialization involved in these activities helps prevent the isolation, loneliness and depression that are often a result of prolonged hospitalization; that, in turn, places them at a greater risk for complications in both their physical and mental health. Therefore, without interventions that include regular exercise and social/spiritual activity, this degenerative process leads to more serious, and sometimes irreversible, states of debilitation and delirium (Inouye 2006).

Studies support the premise that elderly patients who are admitted to hospital are prone to both physical and cognitive dysfunction. In fact, according to Inouye and colleagues (2000), approximately 34% to 50% of hospitalized older adults experience some degree of functional decline, which is associated with prolonged hospital stays, increased mortality, higher rates of long-term institutionalization, increased need for rehabilitation services and greater healthcare expenditures (Inouye et al. 2000). Other studies report that among seniors, pre-hospital rates of delirium range from 14% to 24% and increase to approximately 60% of those in post-acute care. In addition, mortality is more probable among patients suffering with delirium, with rates as high as 76% (Saxena and Lawley 2009). Researchers have suggested that strategies to prevent delirium among hospitalized elderly patients have proven effective when directed towards addressing the six main risk factors: (a) orientation and therapeutic activities for cognitive impairment, (b) early mobilization, (c) minimizing psychoactive drugs, (d) interventions to prevent sleep deprivation, (e) adaptive communication and equipment for vision and hearing impairment and (f) early interven-

tion for volume depletion (hypervolaemia) (Saxena and Lawley 2009). Studies also support the effectiveness of a cognitive-behavioural focused intervention with patients facing chronic illnesses. Greer and colleagues (1992) studied cancer patients experiencing psychological distress as measured by anxiety, depression and helplessness and lack of a “fighting spirit.” Interventions – which included discussions related to coping strategies, concrete problem solving and increased communication – led to lower degrees of psychological distress, a better attitude towards healthcare and a greater “fighting spirit” (Greer et al. 1992). Other studies have reported improvement in functional status as a result of multidisciplinary interventions that included exercise, increasing staff involvement in rehabilitative efforts and cognitive awareness sessions for patients (Mudge et al. 2008).

Members of the Continuous Quality Improvement (CQI) Council of the Sub-Acute Medicine and Palliative Care program at London Health Sciences Centre aimed to combat the incidence of depression and delirium among elderly patients on their unit by introducing the Lunch Bunch, a program that involves staff and patients’ sharing a meal together as well as participating in a series of light rehabilitative exercises.

Setting

University Hospital (UH) campus, belonging to the London Health Sciences Centre (LHSC), is a 350-bed acute care teaching hospital serving the region of southwestern Ontario. The Sub-Acute Medicine Unit (SAMU) and Palliative Care Unit is a subsidiary of the medicine program and may accommodate up to 15 inpatients who meet the necessary requirements for extended care. Patients on the SAMU/Palliative Care floor are typically transferred from an acute care unit in the hospital after they have become stable, yet require continued nursing care for rehabilitative or palliative reasons. These individuals may be, for example, experiencing “failure to cope” with their illness, recovering from the sequelae of an acute infection, entering end-stage cancer or in various states of dementia. The patients’ ages range from 60 to 98 years, and they present with a broad spectrum of functional ability. Patient care is provided by physicians in the medicine program, a number of registered nurses (RNs) and one registered practical nurse (RPN), as well as housekeeping and support service workers (SSWs). Referrals to professional support staff such as spiritual care, social work, physiotherapy and dietetics are done by request and consultation with the primary healthcare team.

Design and Implementation

The Lunch Bunch initiative is a twice-weekly exercise and socialization program targeted at sub-acute patients awaiting transfer to long-term care facilities in the community or returning to their homes.

Having assessed the need for a multidisciplinary intervention, particularly for SAMU patients, the CQI team benchmarked other units for existing programs within LHSC. At Victoria Hospital, the sister campus to UH, one such program implemented once weekly has run successfully for some time now. The leadership for this program is provided primarily by the physiotherapy (PT) staff, with a focus on a 20-minute exercise program followed by a time of socialization and conversation among patients. The program takes place mid-morning, with tea and cookies being provided for patients. The area in which the program is held is the PT assessment room, which can accommodate up to seven patients and includes a kitchen, a large recreational space, light exercise equipment and a cozy seated section for meals and conversation.

Customizing the program for the University Hospital site involved several key factors. At UH, nursing staff took the lead for this initiative and partnered with physiotherapy and spiritual care staff for additional support. In adapting the program to the environment, the CQI team decided to integrate it into the patients' daily routine therefore, the choice to was made to meet at lunch time. The group began with a short exercise program led by physiotherapy, followed by a communal time for light conversation. Hospital lunches were delivered to the designated area for all participants. Patients were encouraged to feed themselves while staff assisted only when indicated to optimize nutrition and fluid intake. Infection control measures were strictly followed, including hand washing and exclusion of patients who were isolated for potential or confirmed cases of *Clostridium difficile* (*C. difficile*).

Inclusion criteria

Initial criteria for selecting participants:

- Able to follow instruction
- Taking part in the PT case load exercise program
- Medically stable
- Not a flight risk
- Those on contact precautions (i.e., methicillin-resistant *Staphylococcus aureus* (MRSA) could attend; those with active *C. difficile* were excluded.

Unfortunately, owing to space restrictions, no more than four individuals may attend each group session. The minimum staffing requirement includes one nurse and one other supportive staff member, often from spiritual care, physiotherapy or a student nurse.

Objectives

- To enhance patient endurance, movement, balance and ability to tolerate activity
- To enhance cognitional functionality as patients support one another through conversation and sharing of experiences, both successes and challenges
- To encourage independent feeding, nutritional and fluid intake
- To informally assess patients' functional ability
- To facilitate physical and emotional transition from independent living to a structured living facility
- For staff and patients to develop therapeutic relationships in a non-formal setting

Implementing the program was relatively simple. Space was reserved in a training room on the same floor as the unit. Lunches were rerouted to that space and provided to patients once their exercise program was completed. A list of potential patients are confirmed the morning of the program, followed by checking for patients' willingness to attend, their availability (e.g., timing of tests) and current medical condition.

Description of the Program

Patients would walk independently or were assisted to the designated area at noon on Tuesdays and Thursdays. On Thursdays, the physiotherapist would conduct a seated exercise program to music appropriate to the age group (e.g., "golden oldies") for approximately 10–15 minutes.

During lunch, patients would engage in conversation with staff and with one another. In some sessions, a structured conversation might be introduced that invited patients to participate in self-reflection, share stories of past memories or discuss current events. Thanksgiving was an opportunity to talk about family traditions and childhood experiences. In some sessions, conversations were focused on the challenges of aging, with patients offering their experiences and coping strategies. One patient remarked, "old age is not all it's cracked up to be." That opened up the conversation to talk about what made life worth living; the patients often reported the chance to see grandchildren, the caring received from loved ones and phone conversations with distant friends. This listing of

“positive attributes” is one strategy encouraged by Propst (1988) for patients dealing with depression (Cole and Pargement 1999). One patient took pride in encouraging his hospital “roommate” to participate in the Lunch Bunch, expressing satisfaction that he could still make a contribution towards helping others. One elderly patient joined the group saying he didn’t want to remember past happier times because they cast a depressing light on his present; before too long, he was claiming his share of the conversation and telling parts of his story. Participants agreed that humour was the best coping mechanism, and often some quiet comment would create a ripple of laughter around the circle. Others shared their fears as they transitioned from independence at home to institutional care.

As time went on, it became clear that patients enjoyed the opportunity to eat communally, to get out of their rooms and to engage in a social time together. They expressed appreciation for the opportunity to share their experiences. In light of this finding, the criteria for participation were eased and more patients were invited to attend. In fact, we found that not all patients were able to engage in conversation, yet even those with some dementia tended to “perk up” during lunch.

The program’s multidimensional objectives make it adaptable. Therefore, when physiotherapy is available, exercise is included; otherwise, the focus is on cognitive and emotional/spiritual functioning.

Positive Outcomes

The intervention was started in October 2012 with a once-weekly frequency. As the team recognized the benefits of the intervention and the willingness of patients to return to the lunch program, the frequency was increased to twice weekly.

Measuring outcomes quantitatively remains challenging given the varying levels of cognitive ability and the high turnover of patients on the unit. Therefore, we depend upon anecdotal measures of outcomes, including observation of the patients who strive to keep up with the conversation and who readily share life experiences, as well as the humour expressed once patients and staff begin to relate to one another on a different level. In addition, there appears to be a therapeutic value in patients’ reflecting upon their circumstances (e.g., how it feels to be in this transition, what supports are present for them, what is missing) as they move from independent living to institutional care. Given the opportunity, patients seek to encourage and support one another in reciprocal relationships, thus exercising the empowerment many feel is threatened at this stage of their lives. Patients who come for the first time, uncertain about what to expect,

begin to look forward to the next sessions. Family members have reported that they heard about the program and appreciated the efforts being made to enrich the lives of their loved ones in hospital. Despite not having any measurable outcome, those involved with the Lunch Bunch project have no doubt that they are providing best practice, and believe that all the proof they need is in the testimonies of those who participate.

The Lunch Bunch also provides an opportunity for nursing assessment of patients' cognitive and mobility functioning and has made it possible to assess for any subtle changes. Barriers to discharge can be addressed and interventions or supports planned ahead of time. Nurses who bring their own lunches to the group have experienced a sense of joining in with patients rather than supervising a program. Sharing stories with patients allows nurses to decrease the power differential implicit in the nurse–patient relationship and enables nurses to experience patients as whole persons, thus avoiding depersonalization. The chaplain has engaged in assessing patients' spiritual needs during the program and, with patient consent, follows up with patients individually as the need arises.

Physicians have reported an observed benefit to their patients' care and improved compliance, consequently making repeated requests to have their other patients included in the program. In addition, healthcare professionals from other units have begun to recognize the positive results and have requested access for patients in other areas of the hospital.

The Lunch Bunch is a program that can be implemented quickly and has proven to be sustainable over time. It requires a relatively small investment by the hospital for what we would argue is a great return. Considering that we are using lunches that are already being delivered, and only one staff nurse from the unit, with one additional support from spiritual care or physiotherapy, has made organizing and running the sessions cost-effective and easy. Not only is this initiative an effective intervention for promoting health and healing in the elderly, it is sustainable in the long term. It could easily be adapted to other settings, in both acute care and long-term facilities, providing much-needed care and support to those who are often forgotten.

Challenges and Recommendations

Space

As may be the case in other hospitals, finding adequate space for our program was a challenge. We are limited to a small education/training room the size of which restricts the program to three or four participants at a time. Creating an

environment that is farther away from the institutionalized nature of the hospital setting would also be beneficial to creating a more comfortable environment for the participants. A more home-like space, with visual and other sensory inputs, is a proven way to open communication with dementia patients. Other more natural settings may include the use of an outside patio garden in the summer when weather permits.

Finding the right patients

There were times when the process of finding patients who met the appropriate criteria seemed a tedious and difficult task. In some sessions, only two patients were available to attend because not all SAMU patients are located on our unit, and those located “off service” were not permitted to participate.

Measuring outcomes

Finding an outcome that is measurable in this population is a challenge. Some patients are available to attend for several sessions; in these cases, a pre and post measure of function might be possible. For others, expeditious discharge minimizes the impact of the program on the patient’s cognitive, spiritual, emotional and physical abilities. Originally, we planned to develop a survey for participants, but recognized that the cognitive abilities of some of our patients would make this difficult to administer. Utilizing a measurement tool to quantify outcomes might be desirable but would depend on a greater investment of time and resources.

A similar program in New Haven, Connecticut claims an improvement in the quality of hospital care for older patients, as measured by hospital outcomes and satisfaction with care for this target population. (Inouye et al. 2000). It may be possible to measure outcomes of the Lunch Bunch through a comparative study of patient satisfaction scores at LHSC between those who have and those who have not participated in the Lunch Bunch program.

Conclusion

The Lunch Bunch program, initiated by the CQI Council on SAMU/PC, has become a popular means of improving the hospital experience for our patients. Exercise and conversations support physical and cognitive/spiritual functioning while allowing the multidisciplinary team to assess and plan further supports for these elderly persons. This program showcases the ability of front-line leaders to innovate with few resources; it takes as little as a meal, some exercise and conversation to show that we are committed to providing the best patient-centred care for those whom we are honoured to serve.

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Correspondence may be directed to: Margot Feyerer, Interfaith Chaplain, London Health Sciences Centre, University Hospital, 339 Windermere Road, PO Box 5339, London, Ontario, N6A 5A5; e-mail: Margot.feyerer@lhsc.on.ca

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