# [AgeFriendlyLogo](http://www.surveymonkey.com/r/7HD3DK5)4Ms Age-Friendly Care Description Worksheet­

# *Hospital & Post-acute Long-term Care Setting*

# Overview

This document is a Word version of the [“4Ms Care Description” electronic form](https://www.surveymonkey.com/r/Z2SGZNJ). This document is a tool for teams to draft their descriptions before their final submissions in the electronic form. The completion of this survey is required to be recognized by IHI’s Age-Friendly Health Systems Movement.

Age-Friendly Health Systems is a movement of hundreds of hospitals, practices, and post-acute and long-term care (PALTC) communities working to ensure the best possible care for older adults. IHI recognizes organizations that have committed to practicing 4Ms care and have described 4Ms care for their setting. Learn more at ihi.org/AgeFriendly or email [AFHS@ihi.org](mailto:AFHS@ihi.org).

The Age-Friendly Health Systems teams at IHI is reviewing practice standards for PALTC communities and will develop a new worksheet for those teams by Winter 2021. For now, a PALTC community may use either worksheet to support their 4Ms work. We recommend the Hospital Setting worksheet for most PALTC communities.

**Health System Name:** Age-Friendly Health System

**Hospital or Post-Acute Long-term Care Setting Name:** Hospital **\*If you are describing how the 4Ms are practiced across multiple practices, please list each practice.**

**Location (City, State):** Boston, MA

**Key Contact (Name, Email):** John Doe

**EHR Platform:** EPIC

|  | **What Matters** | **Medication** | **Mentation** | **Mobility** |
| --- | --- | --- | --- | --- |
| **Aim** | Know and align care with each older adult’s specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care. | If medication is necessary, use age-friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care. | Prevent, identify, treat, and manage delirium across settings of care. | Ensure that each older adult moves safely every day to maintain function and do What Matters. |
| **Engage / Screen / Assess**  Please check the boxes to indicate items used in your care or fill in the blanks if you check “Other.” | List the question(s) you ask to know and align care with each older adult’s specific outcome goals and care preferences:  *Minimum requirement: One or more What Matters question(s) must be listed. Question(s) cannot focus only on end-of-life forms.*  **What is important to you today?**  **What is a goal for you today?** | Check the medications you screen for regularly:  Benzodiazepines  Opioids  Highly-anticholinergic medications (e.g., diphenhydramine)  All prescription and over-the-counter sedatives and sleep medications  Muscle relaxants  Tricyclic antidepressants  Antipsychotics  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_  *Minimum requirement: At least one of the first seven boxes must be checked.* | Check the tool used to screen for delirium:  UB-2  CAM  3D-CAM  CAM-ICU  bCAM  Nu-DESC  Other: \_\_\_\_\_\_\_\_\_\_\_  *Minimum requirement: At least one of the first six boxes must be checked. If only “Other” is checked, will review.* | Check the tool used to screen for mobility limitations:  Timed Up & Go (TUG)  JH-HLM  POMA  Refer to physical therapy  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_  *Minimum requirement: One box must be checked. If only “Other” is checked, will review.* |
| **Frequency** | Once per stay  Daily  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_  *Minimum frequency is once per stay.* | Once per stay  Daily  Other: \_\_\_\_\_\_\_\_\_\_\_\_  *Minimum frequency is once per stay.* | Every 12 hours  Other: \_\_\_\_\_\_\_\_\_\_\_\_  *Minimum frequency is every 12 hours.* | Once per stay  Daily  Other: \_\_\_\_\_\_\_\_\_\_\_\_  *Minimum frequency is once per stay.* |
| **Documentation**  Please check the “EHR” (electronic health record) box or fill in the blank for “Other.” | EHR  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_  *One box must be checked; preferred option is EHR. If “Other,” will review to ensure documentation method is accessible to other care team members for use during the hospital stay.* | EHR  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_  *One box must be checked; preferred option is EHR. If “Other,” will review to ensure documentation method is accessible to other care team members for use during the hospital stay.* | EHR  Other: \_\_\_\_\_\_\_\_\_\_\_\_  *One box must be checked; preferred option is EHR. If “Other,” will review to ensure documentation method can capture assessment to trigger appropriate action.* | EHR  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_  *One box must be checked; preferred option is EHR. If “Other,” will review to ensure documentation method can capture assessment to trigger appropriate action.* |
| **Act On**  Please describe how you use the information obtained from Engage/Screen/Assess to design and provide care. Refer to pathways or procedures that are meaningful to your staff in the “Other” field. | Align the care plan with What Matters most  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_  *Minimum requirement: First box must be checked.* | Deprescribe (includes both dose reduction and medication discontinuation)  Pharmacy consult  Other: \_\_\_\_\_\_\_\_\_\_\_\_  *Minimum requirement: At least one box must be checked.* | Delirium prevention and management protocol including, but not limited to:  Ensure sufficient oral hydration  Orient older adult to time, place, and situation on every nursing shift  Ensure older adult has their personal adaptive equipment (e.g., glasses, hearing aids, dentures, walkers)  Prevent sleep interruptions; use non-pharmacological interventions to support sleep  Avoid high-risk medications  Other: \_\_\_\_\_\_\_\_\_\_\_\_  *Minimum requirement: First five boxes must be checked.* | Ambulate 3 times a day  Out of bed or leave room for meals  Physical therapy (PT) intervention (balance, gait, strength, gate training, exercise program)  Avoid restraints  Remove catheters and other tethering devices  Avoid high-risk medications  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_  *Minimum requirement: Must check first box and at least one other box.* |
| **Primary Responsibility**  Indicate which care team member has primary responsibility for the older adult. | Nurse  Clinical Assistant  Social Worker  MD  Pharmacist  Other: \_\_\_\_\_\_\_\_\_\_  *Minimum requirement: One role must be selected.* | Nurse  Clinical Assistant  Social Worker  MD  Pharmacist  Other: \_\_\_\_\_\_\_\_\_\_  *Minimum requirement: One role must be selected.* | Nurse  Clinical Assistant  Social Worker  MD  Pharmacist  Other: \_\_\_\_\_\_\_\_\_\_  *Minimum requirement: One role must be selected.* | Nurse  Clinical Assistant  Social Worker  MD  Pharmacist  Other: \_\_\_\_\_\_\_\_\_\_  *Minimum requirement: One role must be selected.* |