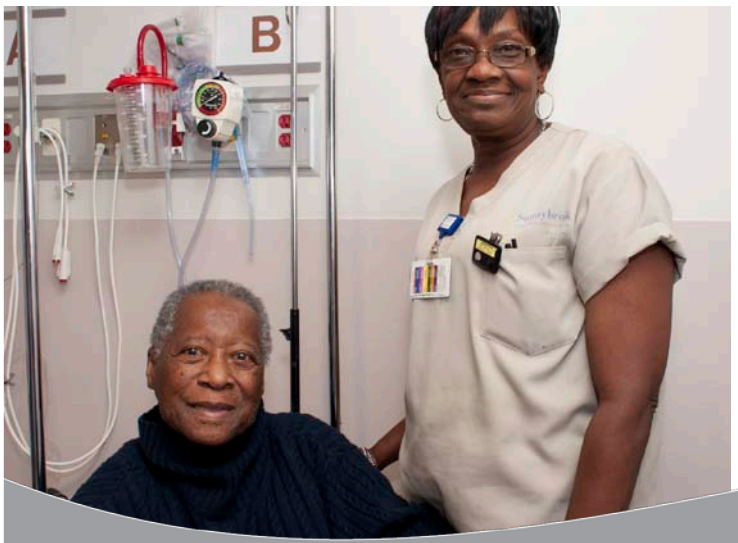
Ontario LHINs

Senior Friendly Hospital Care Across Ontario

Summary Report and Recommendations

September 2011



Ontario
Local Health Integration Network

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The Senior Friendly Hospitals (SFH) logo is used in this report with permission from the Regional Geriatric Program of Toronto.

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Forward

Seeking to continuously improve quality of care and contribute to healthy communities across the province, in September 2010 the Local Health Integration Networks (LHINs) collectively identified the Senior Friendly Hospital (SFH) Strategy as a cross-LHIN priority for province-wide implementation. With clinical leadership from the Regional Geriatric Programs (RGPs) of Ontario, the SFH Strategy is being launched across all LHINs to foster hospital environments that respond to seniors' physical, cognitive, and psychosocial needs to promote health, safety, patient/family engagement, and satisfaction.

The overall vision of the Senior Friendly Hospital Strategy is to enable seniors to maintain optimal health and function while they are hospitalized so that they can transition successfully home or to the next appropriate level of care.

The SFH Strategy will directly contribute to the shared health system priorities of reducing emergency department wait times, alternate-level-of-care, and achieving excellent care for all. It is a significant quality improvement strategy, currently being implemented by all 14 LHINs to help hospitals deliver on Ontario's *Excellent Care for All Act's* mandate to improve the quality and value of the patient experience. It will also support the commitments made by hospitals and their partner agencies to improve the health of older adults in our communities.

This report highlights the important work that Ontario hospitals have already undertaken towards improving senior friendly care and identifies opportunities for hospitals and LHINs to build upon this work.

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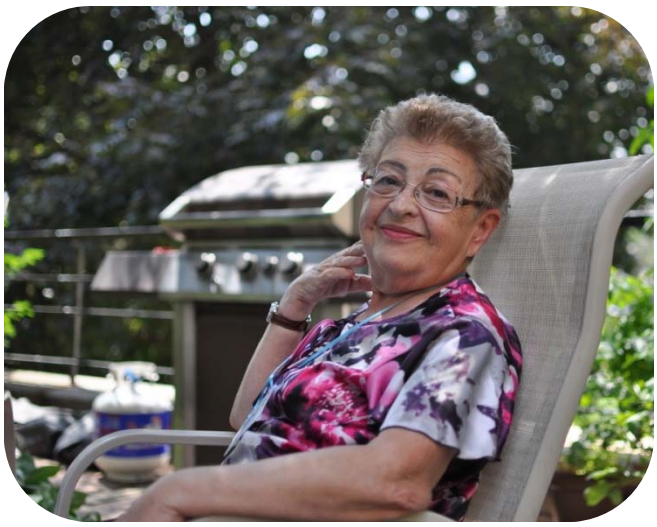

An aging society has many implications on the well-being of urban and rural populations. Promoting successful aging by supporting the independence of older adults is essential to building and sustaining healthy communities. Ontario's population is rapidly growing older, with the proportion of seniors aged 65 and over expected to more than double by 2036. Ontario's oldest seniors, aged 90 and over – more than 20 percent of whom are considered frail – are expected to more than triple in number from 73,000 to 261,000 during this same time period.[1]

Frailty is associated with the presence of multiple chronic health conditions, vulnerability to loss of function, and greater health care needs. The proportion of seniors in Ontario's hospitals is ample justification for a fundamental shift in focus, one that recognizes that the care of older adults is a core business of these institutions. Ontario's hospitals report that their total inpatient days accounted for by seniors averages 43 to 73 percent (unweighted) across each of the Local Health Integration Networks (LHINs). Historically, the priorities surrounding hospital design have focused on rapid diagnosis, management of serious illness, and operative procedures. This paradigm has not proven well suited to the complex needs of older persons, who consequently experience adverse events that result in a difficult-to-reverse decline in physical and cognitive function. This, in turn, increases the likelihood of institutionalization and places even greater resource demands on an already burdened health system. Illustrating this, hospitals report that the proportion of seniors accounting for their alternate level of care (ALC) days ranges from 71 to 89 percent (unweighted) across the LHINs. Quality improvement strategies that govern the performance of hospitals and the health system are crucial during this time of population aging to help older adults return to independent living in the community.

The best available evidence indicates that a systemic approach to the management of older adults in hospital settings, one that recognizes the influences of the entire care environment, is fundamental to success. Geriatric hospital care that considers one or more systemic elements has demonstrated cost effectiveness in addition to positive outcomes, including improved

[1] Ontario Ministry of Finance (2010). *Ontario Population Projections Update 2009 – 2036*. Toronto: Queen's Park Printer for Ontario.

physical and cognitive function, decreased rates of institutionalization, decreased length of hospital stay, improved patient and family satisfaction, and better human resource knowledge, collaboration, and retention.

The Senior Friendly Hospital (SFH) Framework, developed and endorsed by the Regional Geriatric Programs (RGPs) of Ontario, offers a comprehensive, organization-wide approach for the care of older adults that integrates the successful elements of evidence informed practices. It forms the basis of this provincial analysis and the recommendations for hospitals moving forward to ensure the best possible health outcomes for frail seniors. In the winter of 2011, all adult hospitals across Ontario completed a self-assessment based on the Senior Friendly Hospital Framework. Results were collated to produce LHIN-wide summary reports, followed by this provincial scan of SFH care – summarized below under the SFH Framework's five domains:

Organizational Support – A formal commitment to senior friendly care, while emergent, is not yet firmly established in Ontario's hospitals. Thirty-nine percent of hospitals have goals for senior friendly care within their strategic plans, and 30 percent have formal commitments from their board of directors. Fifty-six percent of hospitals have designated a senior executive to lead senior friendly initiatives, and 31 percent have formed committee structures for this work. Hospitals in all regions, but particularly in rural practice, indicate that a lack of human resource expertise is a significant barrier. System-level educational opportunities are needed to support human resource development, promoting equity across all settings of practice. In addition, it will allow for the development of "champions" within these settings who can lead continuing knowledge-to-practice activities. Collaborative system-level planning for senior friendly care that includes the community and health system partners will support health system integration and assist hospitals in confidently committing to senior friendly strategies.

Processes of Care – Clinical areas where protocols and metrics are most frequently in place include falls, pressure ulcers, adverse drug reactions, and restraint use. The least common use of protocols and metrics occur with sleep management, continence, hydration/nutrition, dementia-related behaviours, functional decline, and to a lesser extent, delirium. The recognition and management of functional decline and delirium are especially important, as they are causally linked to other potentially adverse outcomes (e.g. falls, pressure ulcers, and continence) and are important determinants of length of stay and hospital discharge. A small number of organizations are reporting the development of programs to address functional decline or delirium, signifying a growing recognition of these significant priorities. Attention to transitions in care is also an important feature of senior friendly hospital practice, and the development of early needs assessment strategies and collaborative partnerships with the community will be essential to addressing this area of performance.

Emotional and Behavioural Environment – All hospitals report a philosophy of patient-centred care, and most incorporate practices that address cultural diversity. Sixty-one percent show evidence of practices customized to address the unique needs of seniors. Twenty-eight percent of hospitals report the incorporation of age-specific satisfaction measures in quality improvement strategies. In the task-oriented hospital world, where training on safety and clinical guidelines predominates, we may be paying insufficient attention to the process features that are important to a sense of well-being and satisfaction for older patients and families.

Ethics in Clinical Care and Research – Complex ethical situations arise in day-to-day practice with older patients. The majority of hospitals – 83 percent across the province – have access to a clinical ethicist who supports staff, patients, and families in these challenging situations. Many organizations without access to an ethicist have identified other appropriate mechanisms to address ethical concerns, and shared community ethics resources might be considered where possible. Seventy-eight percent of hospitals have developed specific policies and procedures to address advance care directives, although these should be reviewed and rewritten to be inclusive of clinical issues beyond resuscitation orders. Regular refresher training in the form of case-based studies or "lunch and learn" sessions is recommended so that staff members continue to take a thoughtful approach to unique ethical challenges that arise.

Physical Environment – Aging physical infrastructures that were not designed for the needs of frail seniors were among the most commonly reported barriers to senior friendly care, even in regions with relatively high knowledge uptake of senior friendly design. The incorporation of senior friendly design resources and clinical knowledge, in addition to accessibility and building code guidelines, is essential to ongoing capital planning, maintenance, supply chain, and procurement activities. This integration of knowledge will ensure that large scale or incremental improvements result in a senior friendly physical environment over time.

SUMMARY OF RECOMMENDATIONS

This survey of SFH practice across the province, considered along with best evidence in the care of older adults, leads to the following recommendations to support hospitals with capabilities in senior friendly care:

RECOMMENDATIONS FOR HOSPITALS
ORGANIZATIONAL SUPPORT
1) Establish board and/or strategic plan commitments for a Senior Friendly Hospital
2) Designate a senior executive/medical leader in the hospital to lead and be responsible for senior friendly initiatives across the organization
3) Train and empower a clinical geriatrics champion(s) to act as a peer resource and to support practice and policy change across the organization
4) Commit to the training and development of human resources via seniors-focused skill development
PROCESSES OF CARE
5) Implement inter-professional protocols across hospital departments to optimize the physical, cognitive, and psychosocial function of older patients – these processes should include high risk screening, prevention measures, management strategies, and monitoring/evaluation processes
6) Support transitions in care by implementing practices and developing partnerships that promote inter-organizational collaboration with community and post-acute services
EMOTIONAL AND BEHAVIOURAL ENVIRONMENT
7) Provide all staff, clinical and non-clinical, with seniors sensitivity training to promote a senior friendly culture throughout the hospital's operations
8) Apply a senior friendly lens to patient-centred care and diversity practices, so that the hospital promotes maximal involvement of older patients and families/caregivers in their care consistent with their personal values (e.g. cultural, linguistic, spiritual)
ETHICS IN CLINICAL CARE AND RESEARCH
9) Provide access to a clinical ethicist or ethics consultation service to support staff, patients, and families in challenging ethical situations
10) Develop formal practices and policies to ensure that the autonomy and capacity of older patients are observed
PHYSICAL ENVIRONMENT
11) Utilize senior friendly design resources, in addition to accessibility guidelines, to inform physical environment planning, supply chain and procurement activities, and ongoing maintenance
12) Conduct regular audits of the physical environment and implement improvements informed by senior friendly design principles and by personnel trained on the clinical needs of frail populations

Hospitals will need support to implement these recommendations. System-level planning on an ongoing basis will be required to ensure that hospitals and the health system work together to promote aging in place.

RECOMMENDATIONS FOR LHINS

1) Provide support* to hospitals to operationalize Senior Friendly Hospital action plans, ensuring coordinated implementation of evidence informed practice across the province
2) Designate a Senior Friendly Hospital champion within the geography of each LHIN
3) Convene a LHIN-wide organizing body (e.g. Steering Committee) to facilitate integrated service planning with respect to senior friendly care that supports the needs of the community and encourages cross-sector partnerships in health care delivery – consider including representation from hospital organizations, primary care, community services, LTC facilities, seniors, and their families
4) Ensure alignment of the Ontario Senior Friendly Hospital Strategy with other provincial priorities and processes (e.g. Hospital Quality Improvement Plans)
5) Identify metrics to assist hospitals in measuring the success of province-wide Senior Friendly Hospital initiatives

* Support could include: educational resources, best practice guidelines etc.

The recommendations in this report will help hospitals perform as senior friendly organizations. The recommendations for LHINs will support hospitals and help to integrate the performance of hospital organizations within a health system that is senior friendly, promoting partnerships between health service providers and, in turn, optimizing transitions in care. This provincial summary has provided an environmental scan and has revealed emergent promising practices that address functional decline, delirium, and transitions in care. Expert opinion and evidence from the healthcare literature support the significance of these practices as they are linked causally to patient and system outcomes such as physical and cognitive function, safety, satisfaction, discharge options, length of stay, and readmissions. Also important is the ability to leverage promising practices, scale existing interventions, and impact emergency department (ED) wait times and ALC.

For these reasons, it is proposed that action plans that address the clinical priorities of (1) functional decline, (2) delirium, and (3) transitions in care be developed.

PRIORITY #1 FUNCTIONAL DECLINE – Implement inter-professional early mobilization protocols across hospital departments to optimize physical function

PRIORITY #2 DELIRIUM – Implement inter-professional delirium screening, prevention, and management protocols across hospital departments to optimize cognitive function

PRIORITY #3 TRANSITIONS IN CARE – Support transitions in care by implementing practices and developing partnerships that promote inter-organizational collaboration with community and post-acute services

2 The Aging of Ontario's Population
An Imperative for Senior Friendly Hospital Care

Ontario, like the rest of Canada, is experiencing the realities of an aging population, with rates of frailty on the rise. In 2007/08, 16.8 percent of the province's population was over the age of 65. Of Ontario's seniors, 12 percent are 85 years of age or older. One in five people in this age cohort are considered frail, a condition associated with increased health care utilization and greater dependence. Significantly, this age group has increased in number by 36 percent between 2002/03 and 2008/09, representing the fastest growing rate of any age cohort in the province.[2]

Across the country, seniors account for a third of all acute care hospitalizations and almost half of all hospital days.[3] These results were mirrored in this study. Across Ontario's Local Health Integration Networks, the unweighted average total hospital days accounted for by seniors ranged from 43 to 73 percent. The unweighted average alternate level of care (ALC) days ranged from 71 to 89 percent. With a rapidly aging population, these system pressures will continue to compound unless mitigating strategies that govern the way hospitals perform are implemented.

Historically, the priorities surrounding hospital design have focused on rapid diagnosis, management of serious illness, and major operative procedures. For frail older patients, however, this entails a difficult, if not hazardous experience characterized by less than optimal outcomes and functional decline. The current acute care paradigm has not proven well suited to the needs of older persons with multiple acute and chronic conditions. Additionally, increasing costs of hospital care have created pressures to further reduce lengths of stay, increasing the tensions between hospital care and the needs of older patients, particularly those with more complex and chronic conditions.

For older patients, the benefits of hospital care are often compromised by the experience of hospitalization itself, presenting risks for adverse events and functional loss that has a significant impact on an older person's discharge trajectory. The greater complexity of care needs among older adults increases the risk for preventable adverse outcomes and complicates the transition out of hospital.[4] In addition to the normal physiological changes of aging, older patients may have multiple co-morbidities and experience the complex interaction of chronic conditions. The patterns of relapse and recurrence in frail older patients create a set of complex physical, social,

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[2] Institute for Clinical Evaluative Sciences (2010). *Aging in Ontario: An ICES Chartbook of Health Service Use by Older Adults*. Toronto: Institute for Clinical Evaluative Sciences.

[3] Statistics Canada (2006). *Health Reports*, Catalogue 82-003-XPE 16: 33-45

[4] Parke B, and NL Chappell (2010). Transactions between older people and the hospital environment: A social ecological analysis. *Journal of Aging Studies* 24: 115-124.

and functional consequences that are not well-served by the episodic focus of acute care.[5] With this clinical complexity, older patients frequently present with atypical symptoms of disease. Older patients may also be slower and less reliable historians, and those with sensory or communication deficits are at increased risk of inadequate and incorrect assessment in acute care. Complicating this even further, they tend to participate less actively in medical encounters and ask fewer questions – particularly the type of questions that might prevent medical errors.[6] All of these factors contribute to misdiagnosis, delayed diagnosis, or under-diagnosis. With limited physiological and psychosocial reserves, it is easy to see why older people experience difficulty in recovering from illness and are at higher risk of complications and functional decline. Furthermore, without measures promoting a senior friendly culture in care and service across the organization, patient and family engagement and satisfaction with the hospital experience are compromised.[7]

Embedding evidence-based approaches in the delivery of care to older adults requires a systemic approach that considers the influences of the entire care environment. Several models of acute care practice have been developed to address multiple systemic factors. Acute Care for the Elderly (ACE) units combine environmental modifications with an inter-professional model of practice that focuses on functional decline and patient-focused early discharge planning.[8] Another model, the Hospital Elder Life Program (HELP), identifies patients at risk of delirium and functional decline, and incorporates hospital volunteers in protocols designed to address these concerns.[9] The Nurses Improving Care for Healthsystem Elders (NICHE) program places a focus on education, organizational strategies, inter-professional protocols and collaboration, and the geriatrics champion model.[10] By adopting multi-dimensional approaches, these models of acute care have demonstrated cost-effectiveness and improved outcomes, including increased rates of

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[5] Fisher R (2002). The Role of Specialized Geriatric Services in Acute Hospitals. *Geriatrics and Aging* 5(5): 48-51.

[6] Kapp M (2001). Medical Mistakes and Older Patients: Admitting Errors and Improving Care. *Journal of the American Geriatrics Society* 49: 1361 – 1365.

[7] Parke B, and NL Chappell (2010). Transactions between older people and the hospital environment: A social ecological analysis. *Journal of Aging Studies* 24: 115-124.

[8] Landefeld CS, RM Palmer, DM Kresevic, RH Fortinsky, and J Kowal (1995). A randomized trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. *New England Journal of Medicine* 332: 1338-1344.

[9] Inouye SK, ST Bogardus, DI Baker, L Leo-Summers, and LM Coonley (2000). The hospital elder life program: a model of care to prevent cognitive and functional decline in older hospitalized patients. *Journal of the American Geriatrics Society* 48(12): 1697-1706.

[10] Capezuti E, and T Fulmer, eds (2009). *NICHE Planning and Implementation Guide*. New York, New York: Hartford Institute for Geriatric Nursing.

discharge home, decreased cognitive and functional decline, decreased length of stay, increased patient and family satisfaction, and increased staff knowledge and retention.[11]

The concept of the "elder friendly hospital" was first proposed by Belinda Parke, who described an organization-wide model of care-giving for older patients.[12] The Senior Friendly Hospital Framework, developed and endorsed by the RGPs of Ontario, builds on these concepts and provides a practical guide for health care design that maximizes health outcomes for frail seniors and for the health system.

[11] Boltz M, E Capezuti, and N Shabbat (2010). Building a framework for a geriatric acute care model. *Leadership in Health Sciences* 23(4): 334-360.

[12] Parke B, and L Stevenson (1999). Creating an Elder-Friendly Hospital. *Healthcare Management Forum* 12(3): 45-48.

3 A Blueprint for Ontario's Hospitals
The Senior Friendly Hospital Framework

The Senior Friendly Hospital Framework describes an **organization-wide approach** that can be applied to planning and decision making. Recognizing the complexity of frailty and the vulnerability of seniors to unintended consequences of hospitalization that compromise their function and well-being, the senior friendly hospital provides an environment of care-giving and service that promotes safety, independence, autonomy, and respect. As vulnerable seniors typically require health services across the continuum of care, a senior friendly hospital functions as a partner within the health care system, providing a continuity of practice that optimizes the ability of seniors to live independently in the community.

The Senior Friendly Hospital Framework has five components:

1) **Organizational Support –** There is leadership and support in place to make senior friendly care an organizational priority. Hospital leadership committed to senior friendly care empowers the development of human resources, policies and procedures, care-giving processes, and physical spaces that are sensitive to the needs of frail patients.

2) **Processes of Care –** The provision of hospital care is founded on evidence and best practices that acknowledge the physiology, pathology, and social science of aging and frailty. Care is delivered in a manner that ensures continuity within the health care system and in the community, so that the independence of seniors is preserved.

3) **Emotional and Behavioural Environment –** The hospital delivers care and service in a manner that is free of ageism and respects the unique needs of patients and their caregivers, thereby maximizing satisfaction and the quality of the hospital experience.

4) **Ethics in Clinical Care and Research –** Care provision and research are conducted in a hospital environment that possesses the resources and capacity to address unique ethical situations as they arise, thereby protecting the autonomy of patients and the interests of the most vulnerable.

5) **Physical Environment –** The hospital's structures, spaces, equipment, and facilities provide an environment that minimizes the vulnerabilities of frail patients, thereby promoting safety, independence, and functional well-being.

This framework provides a common pathway to engineer positive change, and can be adapted to the unique context of any hospital. While all five components of the Senior Friendly Hospital Framework are required for optimal outcomes, it is recognized that implementing some of the

framework's elements – major updates to the physical environment, for instance – are long-term undertakings and that a staged approach to change is most feasible and practical.

4 The Ontario Senior Friendly Hospital Strategy

The Ontario Senior Friendly Hospital Strategy is an ongoing improvement initiative that aims to promote hospital practices that better meet the physical, cognitive, and psychosocial needs of older adults. The Local Health Integration Networks committed support to the implementation of a Senior Friendly Hospital Strategy as part of their broader commitment to enhance the care of seniors within hospitals. Such enhancement will increase the ability of seniors to transition safely back to the community, an essential component of an integrated, system-wide effort to reduce the time people spend waiting in emergency departments and in alternate level of care. Moreover, a systematic approach to improving hospital-based care for seniors will increase capacity to meet the quality and safety improvements required under the *Excellent Care for All Act*. The Senior Friendly Hospital Strategy is aligned with existing priority projects being led by the LHINs. These include the Integrated Provincial Falls Prevention Program, which is working to lessen the burden of falls on individuals and the health care system; the Home First strategy, which supports patients in their homes with community services for as long as possible; and the LHINs' overall commitment to healthy seniors and communities.

To guide work on this priority, the Toronto Central (TC) LHIN established a Senior Friendly Hospital Strategy Task Group in the summer of 2010 comprising representatives from acute, rehabilitation, and complex continuing care hospitals, as well as the Community Care Access Centre (CCAC). The Regional Geriatric Program of Toronto was engaged as a partner to provide expert clinical consultation and to produce two guiding documents: the background document, which describes the five-domain Senior Friendly Hospital Framework endorsed by the RGPs of Ontario,[13] and a Senior Friendly Hospital self-assessment template.

The self-assessments were piloted in the TC LHIN, where responses from 15 hospitals were used to create a summary report.[14] This report helped to identify common themes in Senior Friendly Hospital care across the LHIN, including promising practices and opportunities for organization- and system-level improvement. With leadership from the 14 LHINs across the province and coordination by the RGP of Toronto, Senior Friendly Hospital self-assessments were completed in all adult hospitals across the province. With the RGPs of Ontario providing local expertise and support, summary reports were prepared describing Senior Friendly Hospital processes in all of the province's LHINs.

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[13] The Regional Geriatric Program of Toronto (2010). *Background Document: Senior Friendly Care in Toronto Central LHIN Hospitals.* Toronto: Toronto Central Local Health Integration Network.

[14] The Regional Geriatric Program of Toronto (2010). *A Summary of Senior Friendly Care in Toronto Central LHIN Hospitals.* Toronto: Toronto Central Local Health Integration Network.

Collectively, the LHIN-wide summary reports describe a range of promising practices that have been implemented across the province, as well as some of the challenges faced by hospitals in delivering senior friendly care. These summaries, along with the current literature on hospital care of older adults, have led to the development of this provincial report. The recommendations herein will help hospitals in Ontario achieve their health safety, wait time, length of stay, alternative level of care, and transitions goals through enhanced care of older patients in a manner that aligns with the Health Quality Ontario-led Hospital Quality Improvement Plans required under the *Excellent Care for All Act*. Provincial indicators to measure the success of this strategy will be developed by January 2012 with the goal of implementation by April 2012.

5 The Senior Friendly Hospital Self-Assessment Process

METHODS

The Senior Friendly Hospital self-assessment process conducted in the TC LHIN in the fall of 2010 resulted in the creation of a summary report in December 2010, and served as a pilot exercise for the provincial roll-out initiated in January 2011. During this second phase, hospitals were supported with a Frequently Asked Questions (FAQ) document prepared by the RGP of Toronto, along with three teleconference sessions held across the province to provide question and answer support. The teleconference sessions also provided a means for hospitals to give direct verbal feedback on data collection processes. In March 2011, completed self-assessments were submitted by hospitals to their LHINs and subsequently to affiliated RGPs (Figure 1). Each RGP assembled a clinical review team, who worked with the LHINs to analyze the quantitative and qualitative information in the self-assessments and generate LHIN-wide summary reports that were completed in June 2011.

Regional Geriatric Program	LHIN	Hospitals
Southwestern Ontario Regional Geriatric Program (London)	Erie St. Clair	5
	South West	14
Regional Geriatric Program Central (Hamilton)	Waterloo Wellington	8
	Hamilton Niagara Haldimand Brant	22
Regional Geriatric Program of Toronto	Central West	2
	Mississauga Halton	3
	Toronto Central	15
	Central	7
	Central East	9
	North Simcoe Muskoka	6
Regional Geriatric Program of South East Ontario (Kingston)	South East	7
Regional Geriatric Program of Eastern Ontario (Ottawa)	Champlain	19
	North West	13
North East Specialized Geriatric Services (Sudbury)	North East	25
	Total Participating Hospitals	155

Figure 1. Regional Geriatric Program affiliations for LHIN-wide hospital summary reports.
All LHINs were supported by a Regional Geriatric Program for data analysis, clinical interpretation, and generation of LHIN-wide summary reports. The number of participating hospitals in each LHIN is shown above. In some cases, data for multiple sites within a hospital corporation were combined into a single self-assessment report.

The LHIN-level summary reports were then forwarded to the RGP of Toronto, who led the development of the provincial summary. Aggregate statistics and qualitative summaries from the LHIN reports were reviewed and interpreted by a clinical team and in applicable cases, QSR NVivo 9 software was used to structure the data for analysis. Teams from each of the RGPs reviewed and provided comments on the provincial summary, first independently and then collectively via teleconference sessions, to reach consensus on the report and its recommendations.

LIMITATIONS

It is important to acknowledge the limitations of the current analysis and summary of SFH care across Ontario. It was clear that hospital organizations had different resources affecting their capacity to collect and report statistical data. In some cases, there were different definitions for the metrics examined in this analysis. This caused variations in the quality and consistency of information, particularly in the quantitative data returned for analysis in the LHIN-wide summaries. Further, the self-assessment template was not developed to perform a detailed environmental scan of all hospital services. The LHIN-wide reports and this provincial summary present common themes in practice, and do not provide a comprehensive comparison of all of the province's hospital services for seniors. Self-assessment methodology has been used successfully in the past to determine training, self-improvement, and coaching needs. However, quantitative and qualitative responses were somewhat influenced by different subjective interpretations of the explorative questions. Accordingly, analyzing the data required clinical and contextual familiarity with the health system and with the types of services discussed in the self-assessment responses. To minimize the effect of this limitation, multiple clinical reviewers worked together to reach consensus for each of the LHIN-wide summaries. In turn, the provincial report was based on conclusions drawn from the LHIN-wide reports, themselves generated by different teams amongst the six RGPs. There were common training sessions and ongoing teleconferences between all of the RGPs during the generation of these reports to maintain consistency of interpretation. The effect of minor differences was minimized by having all teams review and reach consensus on the provincial summary report and recommendations.

6 A Summary of Senior Friendly Hospital Care Across Ontario

6.1 ORGANIZATIONAL SUPPORT

SENIOR FRIENDLY CARE AS AN ORGANIZATIONAL PRIORITY

The Senior Friendly Hospital self-assessment template included inquiries that gauged formal executive and board commitments to senior friendly hospital care. Commitment in this formal manner across Ontario hospitals is emerging. Thirty-nine percent of hospitals have explicit goals related to senior friendly care within their strategic plans, while 30 percent have made a commitment at the board level to becoming senior friendly organizations. A greater proportion of hospitals – 56 percent across the province – have designated a senior executive to lead care of the elderly initiatives, while 31 percent have developed committee structures for this purpose. These results, as well as regional comparisons, are shown in Figures 2 to 5.

In some regions of the province, the Senior Friendly Hospital Framework as a concept had not been widely disseminated prior to the adoption of the Ontario Senior Friendly Hospital Strategy. In particular, small and rural community hospitals expressed concern about their lack of available geriatrics expertise. This concern is linked to the fact that it is often the clinical geriatrics experts within hospitals who influence and inform hospital leadership and encourage the adoption of SFH strategies. Hospitals without these clinical resources want to know how they can be assisted in responding to SFH issues. System-level assistance, led by the LHINs and supported by organizations like the RGPs of Ontario, will be essential to hospitals without geriatrics expertise. System-wide planning of seniors' health services may also encourage more organizations to reflect upon and adopt senior friendly goals within their strategic priorities. Several successful instances of such assistance are evident. In the Central West, Central East, and North Simcoe Muskoka LHINs, for example, seniors' health advisory councils and task forces are leading the development of geriatrics services for the region. The Mississauga Halton LHIN has engaged its hospitals in an All-Inclusive Seamless Services for Independence of Seniors' Today and Tomorrow (ASSIST) model for intake and referral to LHIN-wide specialized geriatrics services. Collaborative planning in the Central East LHIN has resulted in the implementation of the Geriatric Assessment and Intervention Network (GAIN) of clinics in four LHIN hospitals. This coordinated and collaborative planning has resulted in the implementation of key services to support older adults across the health system and leverage available geriatrics expertise. The proportion of hospitals with senior friendly commitments at the board and strategic plan level, and with senior executives designated to elder care initiatives, is higher than the provincial average in these LHINs. LHIN-led assistance can make it easier for hospitals without geriatric expertise to confidently commit to adopting the Senior Friendly Hospital Strategy.

LOCAL HEALTH INTEGRATION NETWORK LEGEND FOR ALL FIGURES	
1 Erie St. Clair	8 Central
2 South West	9 Central East
3 Waterloo Wellington	10 South East
4 Hamilton Niagara Haldimand Brant	11 Champlain
5 Central West	12 North Simcoe Muskoka
6 Mississauga Halton	13 North East
7 Toronto Central	14 North West

Figure 2. Does your hospital have an explicit priority or goal for senior friendly care in its strategic plan?

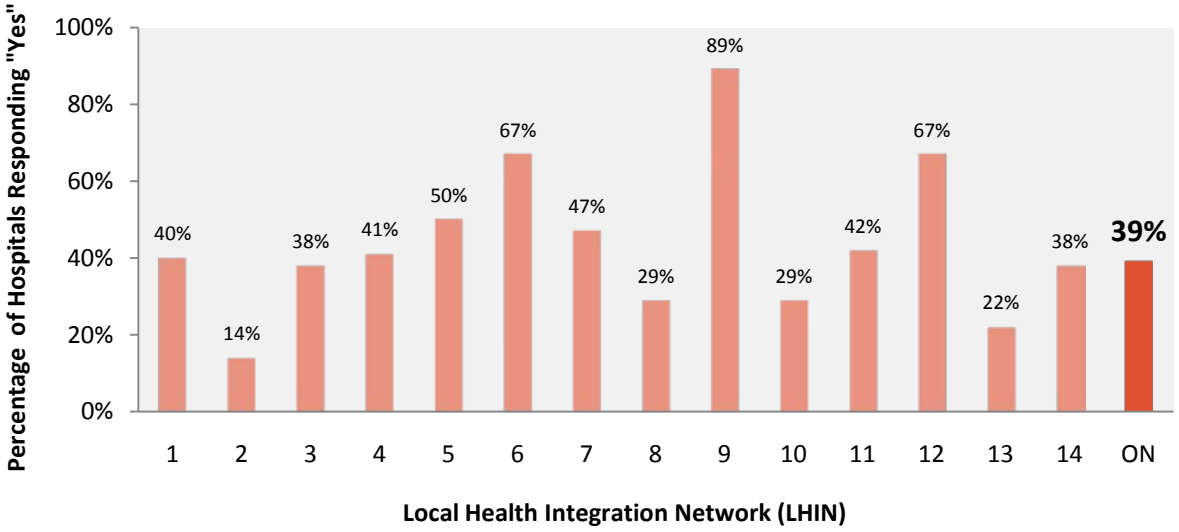


Figure 3. Has the Board of Directors made an explicit commitment to become a Senior Friendly Hospital?

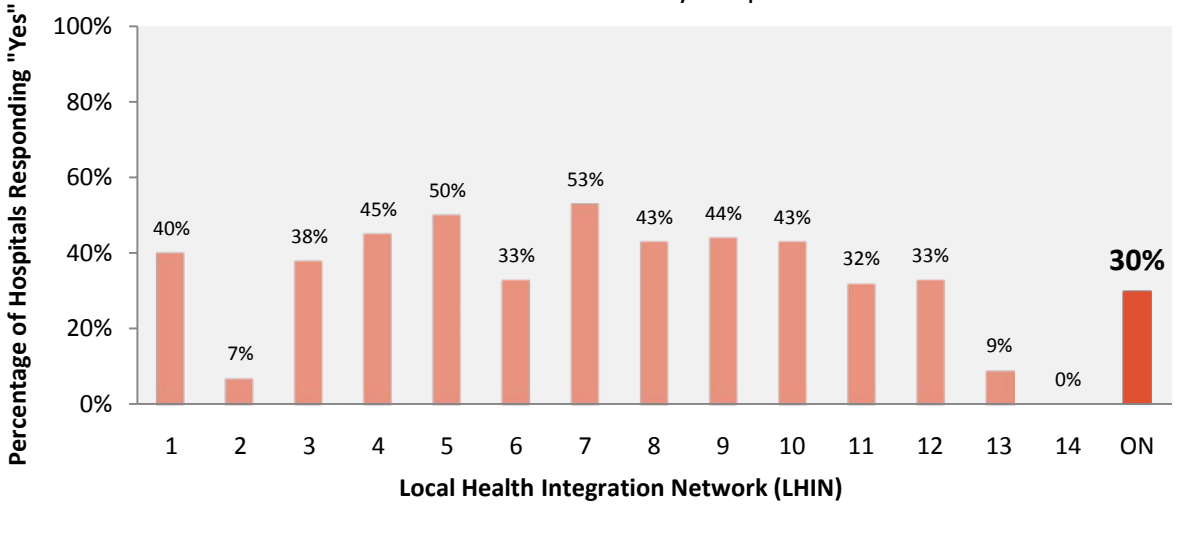


Figure 4. Has a senior executive been designated as the organizational lead for geriatric/care of the elderly initiatives?

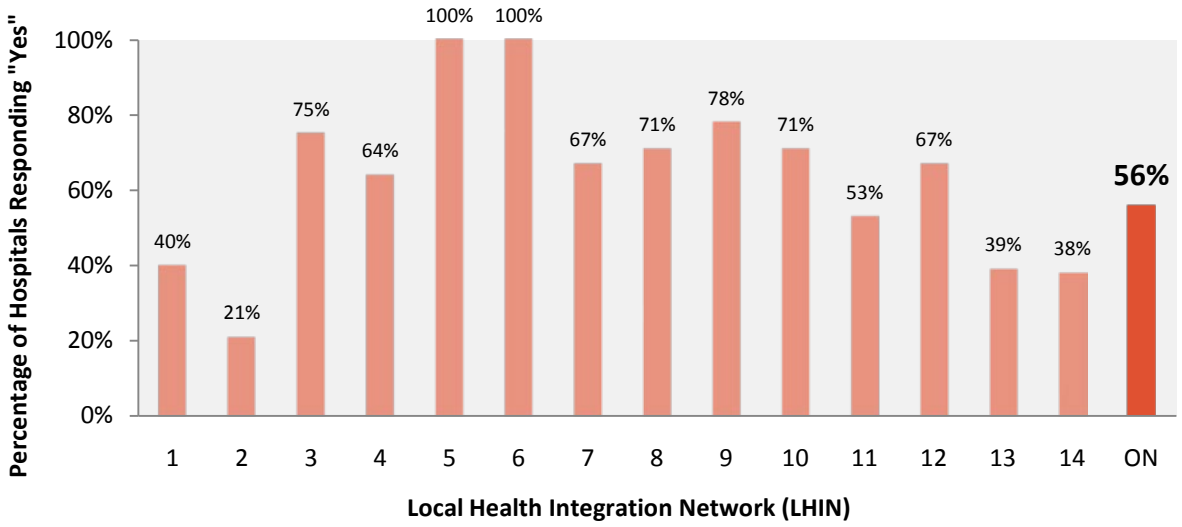
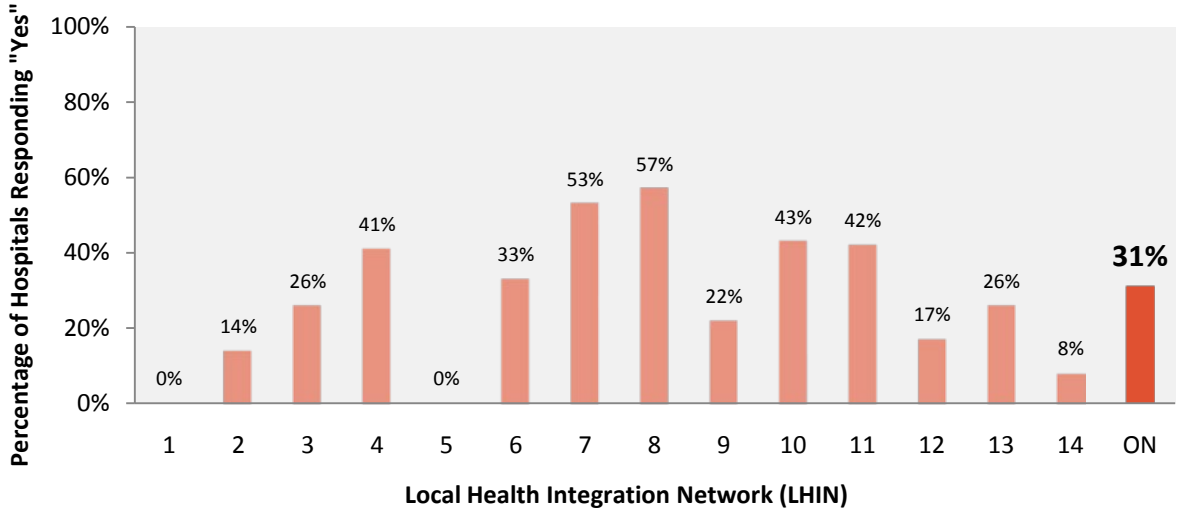


Figure 5. Do you have a designated hospital committee for care of the elderly?



HUMAN RESOURCES DEVELOPMENT FOR FRAILTY-FOCUSED CARE AND SERVICE

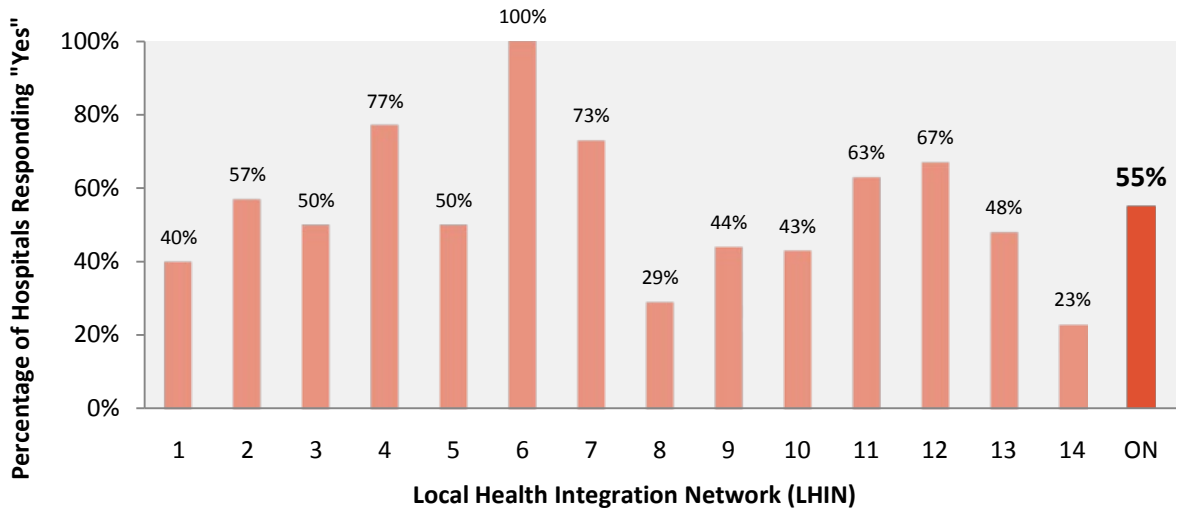
Achieving better outcomes in the care of older adults requires training and awareness on the part of all hospital staff. The care of frail older adults is complex and multi-dimensional, requiring specialized training and experience in geriatrics, inter-professional practice, and inter-organizational collaboration. Organizations can support SFH initiatives through a commitment to the development of all current staff and new hires. Across the province, 55% of hospitals reported initiatives that provide staff with education on the needs of seniors (Figure 6). Most of

these efforts focus on clinical topics such as safety practices and best practice guidelines, and are provided to a limited number of healthcare professionals working in discrete clinical areas. In some instances, broader training is provided. A tiered approach to staff development is recommended, which would include:

- Education and sensitization of all staff, clinical and non-clinical, on aging issues and ageism
- The inter-professional development of SFH process of care skills for all clinical staff
- The training and development of SFH champions to facilitate peer-to-peer training, coaching, and support

Senior Friendly Hospital champions can be recruited from in-place geriatric service providers; but it is typically the case that even without explicit geriatrics experts, many hospitals have staff members with an informal attachment to older adults who might be grown into SFH champions.

Figure 6. Do your staff orientation and education programs have defined learning objectives for senior care?



Given that high proportions of seniors are patients and visitors in virtually all units and departments of hospitals, geriatrics training and champion roles across entire hospital organizations is an essential need. At present, training efforts that focus on geriatrics competencies are mostly limited to larger hospital settings. The majority of hospitals performing in smaller rural settings report significant limitations in financial and human resources to provide a comparable level of education and human resources development. A small number of organizations have made efforts to address these shortages by establishing partnerships with other service providers who have geriatrics expertise. On the whole, access to geriatrics knowledge and expertise remains limited in all settings, especially in smaller communities and rural regions. Strategies to address this issue should be coordinated at the system level.

ENGAGING OLDER ADULTS AND COMMUNITY PARTNERS

Organizational support for Senior Friendly Hospitals is also indicated by the way hospitals engage older patients, family and community caregivers, and partnering agencies. Soliciting feedback and guidance for service development helps hospitals remain responsive to the unique needs of the community. The self-assessment process revealed that while the majority of hospitals use satisfaction surveys and patient relations processes to solicit feedback, the results of these practices are usually not stratified by age. Several hospitals reported using routine structured interviews and focus groups to gather feedback and guidance. Even more encouragingly, some hospitals have developed durable advisory committees that include older adults and external partners. In a few instances, hospitals have developed these advisory structures in partnership with neighbouring hospital and community service providers. Continuing meaningful consultation with the community and health care partners is an important element of organizational support in a Senior Friendly Hospital.

ORGANIZATIONAL SUPPORT – RECOMMENDATIONS

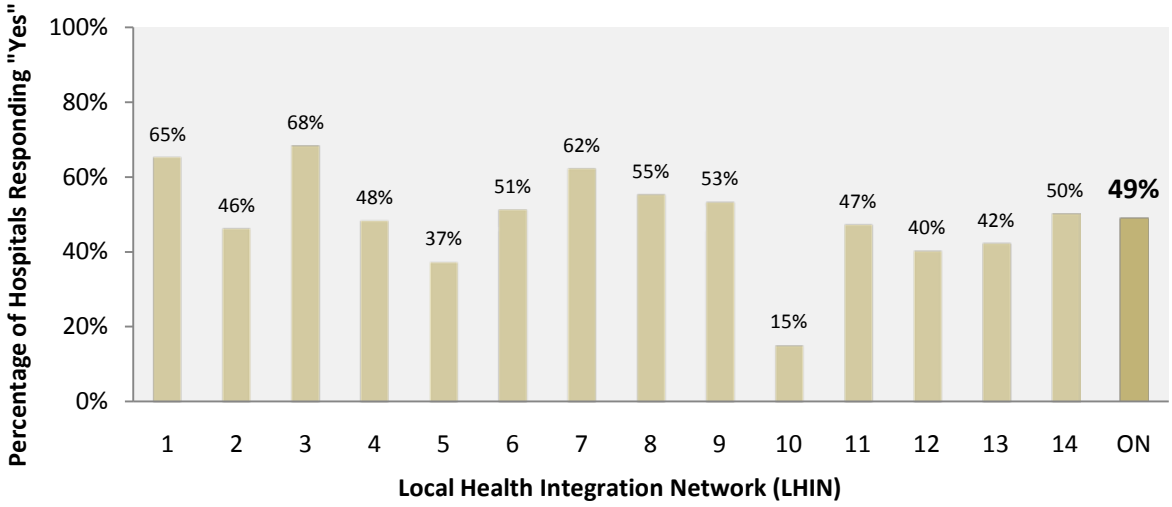
1) Establish board and/or strategic planning commitments for a Senior Friendly Hospital
2) Designate a senior executive/medical leader in the hospital to lead and be responsible for senior friendly initiatives across the organization
3) Train and empower a clinical geriatrics champion(s) to act as a peer resource and to support practice and policy change across the organization
4) Commit to the training and development of human resources via seniors-focused skill development

6.2 PROCESSES OF CARE

AREAS OF CLINICAL RISK TO SENIORS AND THE EMERGENCE OF PRIORITY PRACTICES

Hospitalization can be a pivotal event for frail older adults. It can add years and quality to life or lead to complications that compromise independence in ways that may not be readily reversed. While older patients clearly benefit from hospital care, hospitalization in an environment where processes have not been adapted to the unique health needs of older patients can result in a range of adverse events. For this reason, the SFH self-assessment asked hospitals to report whether they were using protocols and/or monitoring procedures for 13 areas of practice known to present or to mitigate clinical risks in older patients: high risk screening, delirium, falls, continence, pressure ulcers, restraint use, prevention of deconditioning, adverse drug reactions, hydration/nutrition status, pain management, sleep management, management of dementia-related behaviours, and elder abuse. The degree to which protocols are being used and monitoring of these clinical practices is taking place is summarized in Figure 7.

Figure 7. Does your organization have protocols and monitoring metrics for care to address areas of confirmed risk for seniors?



The clinical areas where protocols and monitoring were most commonly in place were falls, pressure ulcers, adverse drug reactions, restraint use, and pain management (Figure 8), some of which are required organizational practices of Accreditation Canada. The clinical areas least likely to have in-place protocols and monitoring procedures include sleep management, continence, hydration/nutrition, management of dementia-related behaviours, prevention of deconditioning and functional decline, elder abuse, and to a lesser extent, delirium and high risk screening (Figure 8).

Area of Clinical Risk	
Most Common Use of Protocols/Monitoring Procedures	Falls Pressure Ulcers Adverse Drug Reactions Restraint Use Pain
Least Common Use of Protocols/Monitoring Procedures	Sleep Management Continence Hydration/Nutrition Management of Dementia-related Behaviours Prevention of Deconditioning Elder Abuse Delirium High Risk Screening

Figure 8. Use of Protocols and Monitoring Procedures for Clinical Areas of Risk to Seniors
Hospitals were asked if protocols or monitoring procedures were in place for clinical areas known to represent risk to frail older adults. The clinical areas in which the use of protocols and monitoring procedures were most and least frequently reported are shown here. The clinical areas of risk included in the self assessment were high risk screening, delirium, falls, continence, pressure ulcers, restraint use, prevention of deconditioning, adverse drug reactions, hydration/nutrition status, pain management, sleep management, management of dementia-related behaviours, and elder abuse.

Of the areas least likely to be guided by protocols and monitoring, the prevention of deconditioning and functional decline and the recognition and management of delirium are especially important. These are linked causally to several other potentially adverse outcomes (e.g. pressure ulcers and continence) and are important determinants of length of stay and discharge destination. Without mobilization, elderly patients lose two to five percent of muscle strength every day, which, if left unmanaged, will lead to loss of function.[15] On the other hand, modest inputs can prevent these risks – a mobility protocol implemented for hospitalized older adults reduced functional decline and lowered length of stay from 8.72 days to 4.96 days.[16] It is promising that the development and implementation of early mobilization and delirium protocols has begun in a number of organizations throughout the province, signifying a growing recognition of this care gap.

DISCHARGE AND TRANSITION PLANNING IN A SENIOR FRIENDLY HOSPITAL

The Senior Friendly Hospital self-assessment process facilitated an examination of discharge planning practices designed to contribute to the early identification of risks and needs, timely coordination of interventions and referrals, and smooth transitions within and across organizations and services. The majority of organizations report practices that lead to the early

[15] Gillis A, and B MacDonald (2005). Deconditioning in the Hospitalized Elderly. *The Canadian Nurse* 101(6): 16-20

[16] Padula CA, C Hughes, and L Baumhover (2009). Impact of a Nurse-Driven Mobility Protocol on Functional Decline in Hospitalized Older Adults. *Journal of Nursing Care Quality* 24(4): 325-331.

identification of risk or discharge needs. In some cases, high risk screening tools are employed on hospital units, triggering appropriate early intervention by the unit-based inter-professional team. Early goal setting and discharge planning discussions with patients and families are also used to determine patients' needs and facilitate early engagement and collaboration with their family and health care team. Partnerships with post-acute and community services are also a cornerstone of most successful discharge planning practices. These include enhanced communication with primary care providers, referrals to available specialized geriatric services, utilization of single access portals to community care, trial discharges, community partnerships such as the Home First and Home at Last programs, and nurse led outreach services to long term care homes. Early initiation of discharge and transition planning upon admission to hospitals, along with simple, structured, and personalized discharge plans that include family and community caregivers, are essential in securing timely and enduring discharges. High levels of teamwork and the ability to work in partnership with the community are also key features of clinical practice in Senior Friendly Hospitals.

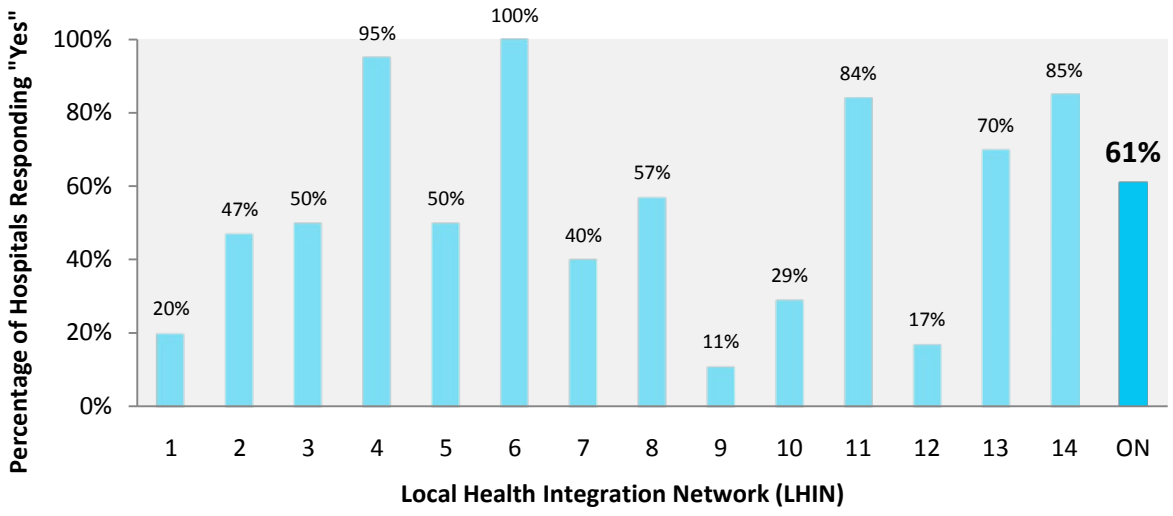
PROCESSES OF CARE – RECOMMENDATIONS

1) Implement inter-professional protocols across hospital departments to optimize the physical, cognitive, and psychosocial function of older patients – these processes should include high risk screening, prevention measures, management strategies, and monitoring/evaluation processes
2) Support transitions in care by implementing practices and developing partnerships that promote inter-organizational collaboration with community and post-acute services

6.3 EMOTIONAL AND BEHAVIOURAL ENVIRONMENT

Senior Friendly Hospitals create an atmosphere of respectful engagement and understanding of the emotional and behavioural needs of older adults and their families. The self-evaluation process revealed that while the majority of hospitals have policies and activities that support patient focused care and cultural diversity, nearly half have not customized these procedures to support the needs of older adults (Figure 9). In the task-oriented hospital world, where training on safety and clinical guidelines predominate, we may not be paying sufficient attention to the process features that are so important to a sense of well-being and to patient and family satisfaction. Some promising practices were demonstrated by a number of organizations. A Senior Friendly Hospital curriculum in the orientation of hospital staff helps to build awareness of the needs of seniors, and encourages the integration of this knowledge into person-centred practice and service. Some organizations deploy staff members and volunteers dedicated to providing navigation, recreation, socialization, menu assistance and cultural diversity services – supporting frail seniors who may require additional personal assistance with these activities.

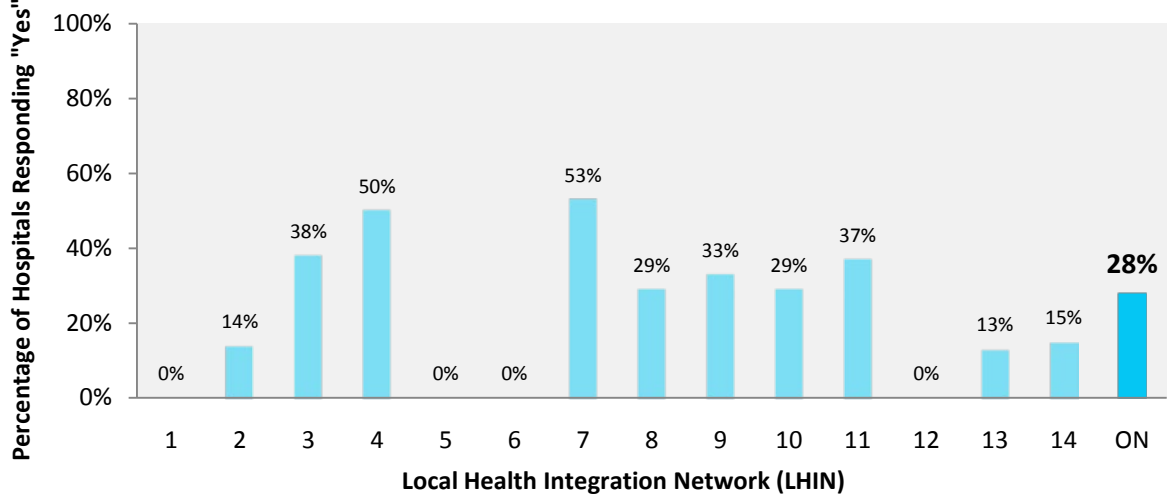
Figure 9. Do you have programs and processes in place to help older patients feel informed and involved about decisions affecting their care?



Hospitals utilize patient satisfaction surveys, mostly via the NRC Picker™ system, to acquire feedback and measure the success of quality improvement initiatives that aim to enhance the experience of patients. Very few hospitals segregate this generalized survey data into age cohorts, a practice that might facilitate a better understanding of the elements of care and service most essential to older patients. Twenty-eight percent of hospitals in the province report the incorporation of age-specific satisfaction measures in quality improvement strategies (Figure 10). Frail seniors may have vision and dexterity limitations that prevent them from completing standard written surveys. In one promising practice, hospital volunteers visit older patients at

their bedside to provide personal assistance with satisfaction questionnaires, thus ensuring that the feedback of older patients is captured in quality improvement processes.

Figure 10. Are age-sensitive patient satisfaction measures incorporated into hospital quality management strategies?



Frail older adults have complex health needs and require an environment that is supportive of their unique communication and sensory abilities. They are also often reliant on family or other caregivers, who form an important part of their circle of care. Optimizing the engagement and involvement of seniors and their families in health care interactions has been identified as a means of improving health outcomes and patient satisfaction.[17] It will be especially important to promote knowledge sharing and encourage the broader implementation of some of the promising practices identified in the LHIN summaries. By doing so, hospitals across the province can move toward an emotional and behavioural environment that fosters partnership with older patients and their families.

EMOTIONAL AND BEHAVIOURAL ENVIRONMENT – RECOMMENDATIONS

1) Provide all staff, clinical and non-clinical, with seniors sensitivity training to promote a senior friendly culture throughout the hospital's operations

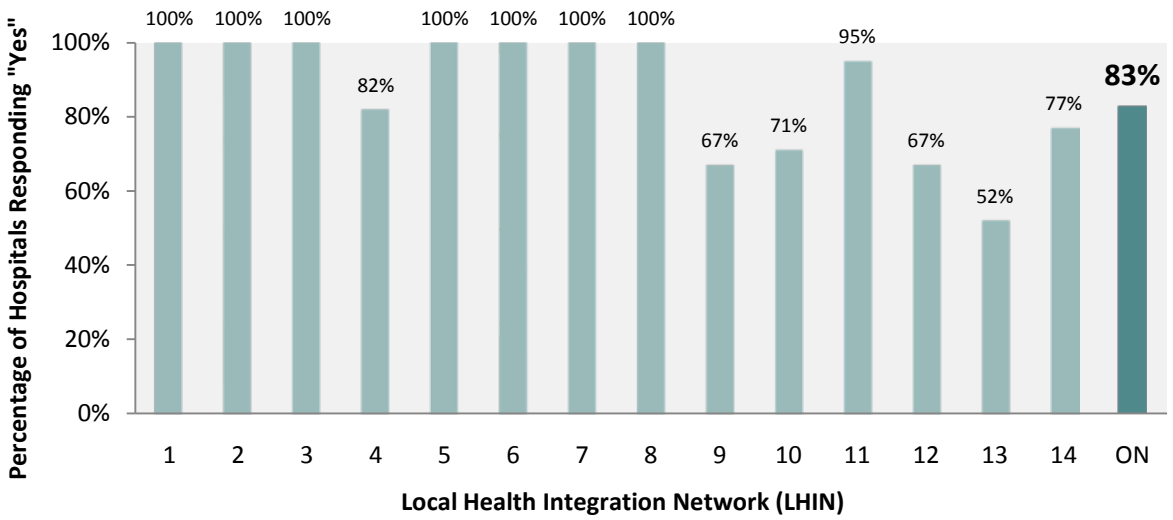
2) Apply a senior friendly lens to patient-centred care and diversity practices, so that the hospital promotes maximal involvement of older patients and families/caregivers in their care consistent with their personal values (e.g. cultural, linguistic, spiritual)

[17] Brown J (2004). *Patient-Centred Collaborative Practice.* Ottawa: Health Canada.

6.4 ETHICS IN CLINICAL CARE AND RESEARCH

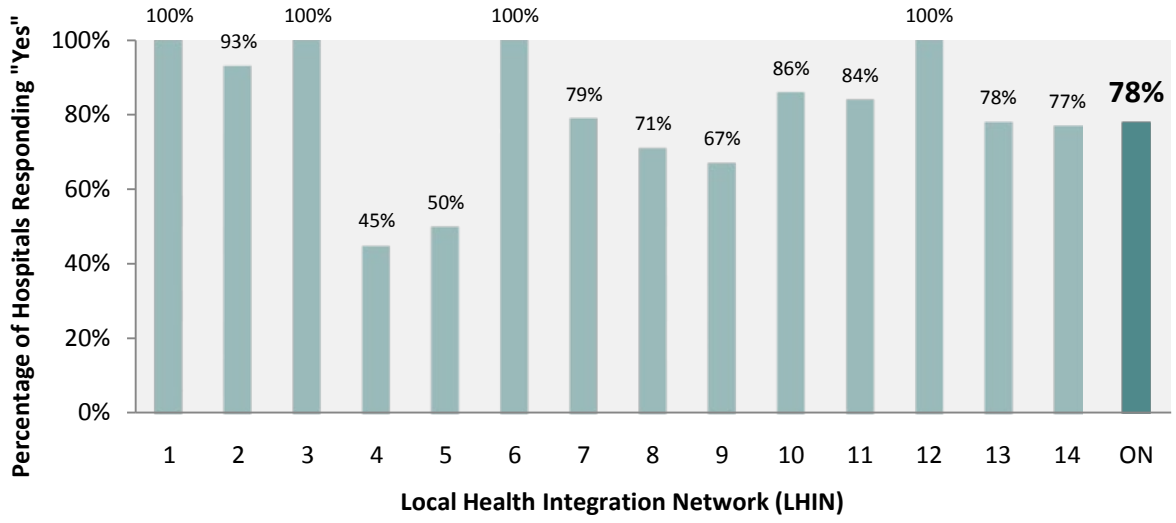
Complex ethical situations arise in day-to-day practice with older patients. It is important for hospitals to have the resources and policies in place to take a thoughtful and consistent approach to these challenges that balances risk, benefit, and patient autonomy. A majority of hospitals – 83 percent across the province – have access to a clinical ethicist to support staff, patients, and families (Figure 11). Organizations without an on-staff ethicist typically acquire services through external sources, share human resources with other organizations, or establish inter-professional ethics committees to provide comparable support. In small rural settings, some organizations report that ethical consultation is ably performed by local physicians who have a close knowledge of the patient and his or her perspectives.

Figure 11. Does your staff have access to an ethicist to advise on ethical issues related to care of older patients?



Organizations across the province have also developed policies to address the autonomy of the patients they serve. For instance, 78 percent of hospitals in Ontario have developed specific policies and procedures to address advance care directives (Figure 12). Many of these policies are limited in scope to resuscitation guidelines, and should be reviewed to be more inclusive of advance care wishes in other clinical areas. For instance, some organizations provide comprehensive advance care planning packages in order to educate patients and families and prepare them for potentially complex care decisions. The majority of hospitals surveyed also demonstrated formal procedures to address capacity and consent in clinical decision making.

Figure 12. Does your hospital have a specific policy on Advance Care Directives?



Ethical situations often present unique cases in practice, as patients' and families' cultural beliefs affect their interpretation of health care priorities. One example reported in the self-assessments involved ambulatory patients who refused to remain in their rooms during an infectious outbreak. The hospital's ethics services worked with the patient safety committee and the infection control department to develop strategies that respected patient autonomy while ensuring the safety of other vulnerable patients. This instance also illustrates the importance of providing regular learning opportunities, such as case studies and "lunch and learns," so that the health care team is continually prepared to take a thoughtful approach to such situations. This is a relatively common practice in the province, especially in mental health settings where extremely challenging situations arise. In hospitals where regular ethics discussions have not been implemented, it may be possible to leverage the mental health community as a system-wide shared learning resource.

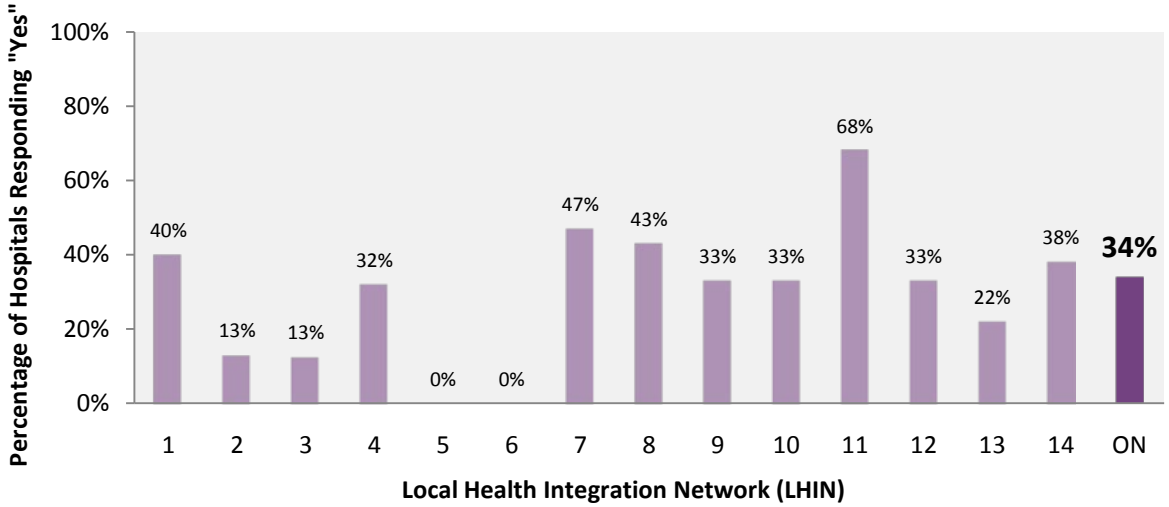
ETHICS IN CLINICAL CARE AND RESEARCH – RECOMMENDATIONS

1) Provide access to a clinical ethicist or ethics consultation service to support staff, patients, and families in challenging ethical situations with older patients
2) Develop formal practices and policies to ensure that the autonomy and capacity of older patients are observed

6.5 PHYSICAL ENVIRONMENT

In all LHINs, the physical environment was cited as one of the most significant barriers to the delivery of Senior Friendly Hospital care. Many older structures were constructed at a time when building codes placed little emphasis on universal access. Most hospitals are currently relying on building code guidelines and Accessibility for Ontarians with Disabilities Act (AODA) legislation to guide the planning and implementation of their physical spaces. There is a significant body of literature related to senior friendly environmental design,[18,19,20] with principles related to clinical care and safety that go beyond accessibility guidelines. Across the province, only 34 percent of hospitals report using senior friendly environmental resources to audit their physical spaces (Figure 13).

Figure 13. Has your hospital conducted any senior friendly environmental audits of physical space using peer-reviewed guidelines?



In the Champlain LHIN, there has been early adoption of senior friendly resources in environmental planning, perhaps associated with enhanced knowledge uptake subsequent to the publication of senior friendly guidelines by the RGP of Eastern Ontario in 2004.[20] While there are still significant environmental barriers, Champlain hospitals have demonstrated a strong commitment to the integration of senior friendly design characteristics in their capital projects. Organizations in other LHINs are also beginning to express a commitment to the incorporation of

[18] Parke B, and K Friesen (2008). *Code Plus: Physical Design Elements for an Elder Friendly Hospital*. Fraser Health Authority

[19] Frank C, J Hoffman, and D Dickey (2007). Development and Use of a Senior Friendly Hospital Environmental Audit Tool. *Canadian Journal of Geriatrics* 10(2): 44-52.

[20] O'Keeffe, J (2004). Creating a Senior Friendly Physical Environment in our Hospitals. *Geriatrics Today: Journal of the Canadian Geriatrics Society* 7(2): 49-52.

senior friendly design in their capital improvement plans. For instance, an organization that has already conducted a senior friendly environmental audit worked with their facilities management staff to ensure that the floors in patient areas are maintained in a matte, non-glare finish – for seniors with visual impairments, glare on flooring can be distracting and lead to falls. In other cases, hospitals assign clinically trained personnel and enlist community seniors to collaborate with physical design teams and inform them of clinically relevant environmental needs. The utilization of senior friendly design resources by physical planning and implementation teams, supply chain and purchasing staff, and maintenance personnel is essential, ensuring that ongoing capital improvements, whether large scale or incremental, will result in a senior friendly physical environment over time.

PHYSICAL ENVIRONMENT – RECOMMENDATIONS

1) Utilize senior friendly design resources, in addition to accessibility guidelines, to inform physical environment planning, supply chain and procurement activities, and ongoing maintenance
2) Conduct regular audits of the physical environment and implement improvements informed by senior friendly design principles and by personnel trained on the clinical needs of frail populations

7 Recommendations for Senior Friendly Hospital Care in Ontario

The recommendations listed below are organization-level actions that will support Senior Friendly Hospital care. Appendix A lists promising practices identified in the LHIN-wide summary reports that support the recommended action plans.

RECOMMENDATIONS FOR HOSPITALS
Organizational Support
1) Establish board and/or strategic planning commitments for a Senior Friendly Hospital
2) Designate a senior executive/medical leader in the hospital to lead and be responsible for senior friendly initiatives across the organization
3) Train and empower a clinical geriatrics champion(s) to act as a peer resource and to support practice and policy change across the organization
4) Commit to the training and development of human resources via seniors-focused skill development
Processes of Care
5) Implement inter-professional protocols across hospital departments to optimize the physical, cognitive, and psychosocial function of older patients – these processes should include high risk screening, prevention measures, management strategies, and monitoring/evaluation processes
6) Support transitions in care by implementing practices and developing partnerships that promote inter-organizational collaboration with community and post-acute services
Emotional and Behavioural Environment
7) Provide all staff, clinical and non-clinical, with seniors sensitivity training to promote a senior friendly culture throughout the hospital's operations
8) Apply a senior friendly lens to patient-centred care and diversity practices, so that the hospital promotes maximal involvement of older patients and families/caregivers in their care consistent with their personal values (e.g. cultural, linguistic, spiritual)
Ethics in Clinical Care and Research
9) Provide access to a clinical ethicist or ethics consultation service to support staff, patients, and families in challenging ethical situations with older patients
10) Develop formal practices and policies to ensure that the autonomy and capacity of older patients are observed
Physical Environment
11) Utilize senior friendly design resources, in addition to accessibility guidelines, to inform physical environment planning, supply chain and procurement activities, and ongoing maintenance
12) Conduct regular audits of the physical environment and implement improvements informed by senior friendly design principles and by personnel trained on the clinical needs of frail populations

Hospitals will require support to implement these recommendations. Vulnerable seniors typically require health services across the continuum of care. Therefore, a Senior Friendly Hospital functions as a partner within the health care system, providing a continuity of practice that optimizes the ability of seniors to live independently in the community. System-wide planning is essential to ensure that hospitals and the health system work together to promote aging in place.

RECOMMENDATIONS FOR LHINS

1) Provide support to hospitals to operationalize Senior Friendly Hospital action plans, ensuring coordinated implementation of evidence-informed practice across the province
2) Designate a Senior Friendly Hospital champion within the geography of each LHIN
3) Convene a LHIN-wide organizing body (e.g. Steering Committee) to facilitate integrated service planning with respect to senior friendly care that supports the needs of the community and encourages cross-sector partnerships in health care delivery – consider including representation from hospital organizations, primary care, community services, LTC facilities, seniors, and their families
4) Ensure alignment of the Ontario Senior Friendly Hospital Strategy with other provincial priorities and processes (e.g. Hospital Quality Improvement Plans)
5) Identify metrics to assist hospitals in measuring the success of Senior Friendly Hospital initiatives

* Support could include: educational resources, best practice guidelines etc.

The recommendations in this report will help hospitals perform as senior friendly organizations. The recommendations for LHINs will support hospitals and help to integrate their performance within a health system that is senior friendly, promoting partnerships between health service providers and, in turn, optimizing transitions in care. This summary report has provided an environmental scan of SFH practices across the province. To our knowledge, this is the first large-scale systematic survey of Senior Friendly Hospital practices to be conducted in Canada.

Based on the promising practices that emerged in this report, expert opinion, and evidence from the healthcare literature, **the following action plans are proposed to address the clinical priorities of (1) functional decline, (2) delirium, and (3) transitions in care.** Opportunities to leverage promising practices, scale existing interventions, and impact emergency department wait times and ALC were all important considerations in identifying these three priorities. They are also linked causally to patient and system outcomes such as physical and cognitive function, safety, satisfaction, discharge options, length of stay, and readmissions.

Evidence informs us that successful geriatric practices require a holistic approach that recognizes the influences of the entire care-giving environment.[21] The action plans presented below outline

[21] Boltz M, E Capezuti, and N Shabbat (2010). Building a framework for a geriatric acute care model. *Leadership in Health Sciences* 23(4): 334-360.

how the Senior Friendly Hospital Framework recommendations will support these suggested priorities and help optimize positive outcomes:

PRIORITY #1 – FUNCTIONAL DECLINE: *Implement inter-professional early mobilization protocols across hospital departments to optimize physical function*

Rationale and Evidence

- Rates of mobilization in patients admitted to acute care hospitals are unacceptably low – hospitalized older adults who were ambulatory during the two weeks prior to admission, spent a median **43 minutes per day** standing or ambulating[22]
- Immobility is hazardous to the health and well-being of the patient – without mobilization, elderly patients lose two to five percent of muscle strength every day[23]
- Modest inputs can prevent these risks – a mobility protocol implemented for hospitalized older adults reduced functional decline and lowered length of stay from 8.72 days to 4.96 days[24]

System Synergies – alignment with other provincial initiatives

- Provincial Falls Prevention Strategy
- ALC
- ED Wait Times, Length of Stay
- Readmission Rates
- Safety
- Excellent Care for All Act

Benefits of Implementation

- Feasible intervention
- Investment in HR development and process changes emphasize quality and efficiency
- Potential for high impact:

  System – ALC, length of stay, readmissions

  Hospital – ALC, length of stay, readmissions, staff satisfaction, concurrent reduction in complications related to immobility and bed rest (e.g. pressure ulcers, circulatory and respiratory decline)

  Person/Family – reduction in adverse events, improved physical function leading to better outcomes, increased discharge destinations/options

[22] Brown CJ, DT Redden, KL Flood, and RM Allman (2009). The Underrecognized Epidemic of Low Mobility During Hospitalization of Older Adults. *Journal of the American Geriatrics Society* 57: 1660-1665.

[23] Gillis A, and B MacDonald (2005). Deconditioning in the Hospitalized Elderly. *The Canadian Nurse* 101(6): 16-20

[24] Padula CA, C Hughes, and L Baumhover (2009). Impact of a Nurse-Driven Mobility Protocol on Functional Decline in Hospitalized Older Adults. *Journal of Nursing Care Quality* 24(4): 325-331.

PRIORITY #1 – FUNCTIONAL DECLINE
SCREEN Screening of older patients early in admission for risk of functional decline
MANAGE Implementation of evidence-based protocol adapted for local context (see Appendix A for examples of implemented practices)
MONITOR/EVALUATE Comply with hospital indicators defined by Ontario Senior Friendly Hospital Strategy Regular review and reporting to quality and safety committees

Senior Friendly Hospital Framework Recommendations – Activities to Support Priority Area	
Organizational Support	
(1) Board of Director Commitment	• Senior executive lead reports to board • Senior executive leads working group responsible for implementing mobility program • Representation on quality and safety committee
(2) Senior Executive Lead	
(3) Geriatrics Champions	• Serve as peer-to-peer resource and coach in support of mobility protocols • Reinforce formal knowledge-to-practice activities
(4) HR Development	• Formal education on mobility protocols
Emotional & Behavioural Environment	
7) Seniors Sensitivity Training	• Orientation and refresher sensitivity training for all staff, clinical and non-clinical, on aging, person-focused care, and cultural competency integrated with performance appraisal processes
(8) Senior Friendly Person-Centred and Diversity Practices	
Ethics in Clinical Care and Research	
(9) Ethicist Services Available	• Ensure the availability of ethicist or ethics committee to assist clinical teams, patients, and families in complex decision making
(10) Policies for Autonomy and Consent/Capacity	
Physical Environment	
(11) Senior Friendly Design Resources Used in Addition to Accessibility Guidelines (AODA)	• Review ward set up to allow for mobilization • Implement environmental changes to reduce risk of falls • Review equipment purchasing to support maximum patient mobility
(12) Physical Environment Audit and Improvements	

PRIORITY #2 – DELIRIUM: *Implement inter-professional delirium screening, prevention, and management protocols across hospital departments to optimize cognitive function*

Rationale and Evidence

- The rates of delirium in hospitalized older patients is as high as 50 percent, including those who present with delirium at the time of admission, and those who develop delirium over the course of their hospital stay[25,26,27]
- Delirium is associated with adverse events – unmanaged, delirium causes functional decline, prolonged length of stay, higher costs, increased long term care placement, and mortality[25,26,27]
- Evidence-based protocols have been described in the literature[28,29] and standards of practice have been piloted in hospitals in Ontario (see Appendix A for examples)

System Synergies – alignment with other provincial initiatives

- Falls
- Readmission Rates
- ED Wait Times, Length of Stay
- ALC
- Safety
- Excellent Care for All Act

Benefits of Implementation

- A readily scalable intervention
- Investment in HR development and process changes emphasize quality and efficiency
- Potential for high impact

  System – ALC, length of stay

  Hospital – ALC, length of stay, staff satisfaction, reduction in complications related to delirium such as falls, use of direct observers, and psychotropic drug use

  Person/Family – reduction in adverse events, better outcomes

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[25] Gillick MR, NA Serrell, and LS Gillick (1982). Adverse consequences of hospitalization in the elderly. *Social Science and Medicine* 16: 1033-1038.

[26] Chisholm SE, OL Deniston, RM Ingrisan, and AJ Barbus (1982). Prevalence of confusion in elderly hospitalized patients. *Journal of Gerontological Nursing* 8: 87-96.

[27] Inouye SK, MJ Schlesinger, and TJ Lydon (1999). Delirium: a symptom of how hospital care is failing older persons and a window to improve quality of hospital care. *American Journal of Medicine* 106: 563-573.

[28] Inouye SK, CH van Dyck, CA Alessi, S Balkin, AP Siegal, and RI Horwitz (1990). Clarifying confusion: the confusion assessment method. A new method for detecting delirium. *Annals of Internal Medicine* 113: 941-948.

[29] Inouye SK, ST Bogardus Jr, DI Baker, L Leo-Summers, and LM Cooney Jr (2000). The Hospital Elder Life Program: a model of care to prevent cognitive and functional decline in older hospitalized patients. *Journal of the American Geriatrics Society* 48: 1679-1706.

PRIORITY #2 – DELIRIUM
SCREEN Screening of older patients early in admission for risk of delirium
MANAGE Implementation of early recognition strategies and evidence-based delirium management protocols adapted for local context (see Appendix A for examples of implemented practices)
MONITOR/EVALUATE Comply with hospital indicators defined by Ontario Senior Friendly Hospital Strategy Regular review and reporting to quality and safety committees

Senior Friendly Hospital Framework Recommendations – Activities to Support Priority Area	
Organizational Support	
(1) Board of Director Commitment	• Senior executive lead reports to board • Senior executive leads working group responsible for implementing delirium program • Representation on quality and safety committee
(2) Senior Executive Lead	
(3) Geriatrics Champions	• Serve as peer-to-peer resource and coach in support of delirium protocols • Reinforce formal knowledge-to-practice activities
(4) HR Development	• Formal education on delirium
Emotional & Behavioural Environment	
(7) Seniors Sensitivity Training	• Orientation and refresher sensitivity training for all staff, clinical and non-clinical, on aging, person-focused care, and cultural competency integrated with performance appraisal processes
(8) Senior Friendly Person-Centred and Diversity Practices	
Ethics in Clinical Care and Research	
(9) Ethicist Services Available	• Ensure the availability of ethicist or ethics committee to assist clinical teams, patients, and families in complex decision making
(10) Policies for Autonomy and Consent/Capacity	
Physical Environment	
(11) Senior Friendly Design Resources Used in Addition to Accessibility Guidelines (AODA)	• Review ward set up to create an environment that minimizes delirium • Review equipment purchasing to support those at risk of delirium
(12) Physical Environment Audit and Improvements	

PRIORITY #3 – TRANSITIONS IN CARE: *Support transitions in care by implementing practices and developing partnerships that promote inter-organizational collaboration with community and post-acute services*

Rationale and Evidence

- Upon discharge, 49 percent of patients experience at least one adverse event including medication errors, confusing follow-up instructions, or unnecessary testing[30,31,32]
- Associated with bad outcomes – failed discharges and readmission to hospital
- Evidence-based protocols have been described in the literature[33] and standards of practice have been piloted in hospitals in Ontario (see Appendix A for examples)
- Continuing transition planning, when initiated early, helps close gaps in care, reduce length of stay, reduce readmission rates, lower medication errors, and increase quality of care for seniors, whilst improving partnerships and collaboration in health care delivery

System Synergies – alignment with other provincial initiatives

- ED Wait Times, Length of Stay
- Readmission Rates
- Safety
- Community Partnerships (e.g. Home First, Home at Last, etc.)
- Excellent Care for All

Benefits of Implementation

- Feasible interventions and partnerships
- Investment in HR development and process changes emphasizes quality and efficiency
- Improved inter-organizational collaboration, partnerships, and overall system benefit
- Potential for high impact

  System – improved system integration and performance

  Organization – length of stay, readmission rates, improved partnerships

  Person/Family – reduction in adverse events, better outcomes, satisfaction, improved continuity of care

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[30] Forster A, HD Clark, A Menard, N Dupuis, R Chernish, N Chandok, A Khan, and C van Walraven (2004). Adverse events among medical patients after discharge from hospital. *Canadian Medical Association Journal* 170: 345-349.

[31] Moore C, J Wisnivesky, S Williams, and T McGinn (2003). Medical errors related to discontinuity of care from an inpatient to an outpatient setting. *Journal of General Internal Medicine* 18: 646-651.

[32] Marcantanio ER, S McKean, M Goldfinger, S Kleefield, M Yurkofsky, and TA Brennan (1999). Factors associated with unplanned hospital readmission among patients 65 years of age and older in a Medicare managed care plan. *American Journal of Medicine* 107: 13-17.

[33] Dedhia P, S Kravet, J Bulger, T Hinson, A Sridharan, K Kolodner, S Wright, and E Howell (2009). A Quality Improvement Intervention to Facilitate the Transition of Older Adults from Three Hospitals Back to Their Homes. *Journal of the American Geriatrics Society* 57: 1540-1546.

PRIORITY #3 – TRANSITIONS IN CARE
SCREEN Early needs assessment, identification of transition issues, and engagement/goal setting with patients and families
MANAGE Implementation of clinical protocols adapted for local context (see Appendix A for examples of implemented practices)
MONITOR/EVALUATE Comply with hospital indicators defined by Ontario Senior Friendly Hospital Strategy Regular review and reporting to quality and safety committees

Senior Friendly Hospital Framework Recommendations – Activities to Support Priority Area	
Organizational Support	
(1) Board of Director Commitment	• Senior executive lead reports to board • Senior executive leads working group responsible for implementing care processes and establishing partnerships • Representation on quality and safety committee
(2) Senior Executive Lead	
(3) Geriatrics Champions	• Serve as peer-to-peer resource and coach, work with discharge planners to build partnerships • Reinforce formal knowledge-to-practice activities
(4) HR Development	• Formal education on transitions in care, local resources for seniors, inter-organizational collaboration
Emotional & Behavioural Environment	
(7) Seniors Sensitivity Training	• Orientation and refresher sensitivity training for all staff, clinical and non-clinical, on aging, person-focused care, and cultural competency integrated with performance appraisal processes
(8) Senior Friendly Person-Centred and Diversity Practices	
Ethics in Clinical Care and Research	
(9) Ethicist Services Available	• Ensure the availability of ethicist or ethics committee to assist clinical teams, patients, and families in complex decision making
(10) Policies for Autonomy and Consent/Capacity	
Physical Environment	
(11) Senior Friendly Design Resources Used in Addition to Accessibility Guidelines (AODA)	• Review ward set up and equipment purchasing to promote patient safety, communication, and use of aids to promote information sharing between providers
(12) Physical Environment Audit and Improvements	

8 Looking Ahead – Next Steps

This report will help guide the next phase of the Ontario Senior Friendly Hospital Strategy – implementing positive change in hospitals' senior friendly care through pathways that can be adapted to the unique context of different LHINs and hospitals. In the coming year, LHINs will be working together to address the system-level recommendations contained in this report and will be looking to hospitals to help in the planning of local, regional, and provincial actions to move this strategy forward. Over the short term, LHINs will focus their efforts on developing a coordinated provincial approach to creating positive change across the three clinical priority areas that have been highlighted in this report: functional decline, delirium, and transitions in care. Using a phased approach, LHINs will support hospitals in developing plans to promote Senior Friendly Hospital care in alignment with these three provincial priorities. By spring 2012, LHINs and hospitals will adopt at least one indicator to measure improvements to seniors' care as a result of the strategy.

Appendix A Promising Practices that Support Senior Friendly Hospital Recommendations

Listed below are some of the promising practices identified in the LHIN summary reports that pertain to the identified priority recommendations. The LHIN summary report(s) in which the listed practices are discussed is indicated in parentheses. More information can be found within the summary report for that particular LHIN. The LHIN websites can be accessed at:

http://www.lhins.on.ca/page.aspx?id=848&ekmensel=e2f22c9a_72_308_btnlink

PRIORITY #1 – FUNCTIONAL DECLINE

- Ambulation Assistant Program, "Exercises at the Kitchen Sink" DVD (ESC)
- Hospital Elder Life Program (SW, HNHB, MH, Central, CE, SE)
- Early Mobility (WW, TC)
- Health Outcomes for Better Information and Care (HNHB)
- Short-Term Active Reconditioning (STAR) Program (Central)
- Transitional Care Program for Reactivation (Central)
- Geriatric Activation Program (CE)
- Mobility of Patients when Receiving Food Tray (CE)
- Patients in Motion Program (NSM)
- Inter-Professional Model of Restorative Care (NE)
- Standards for Mobilization of Older Patients (NE)
- ADL Assessment Room (NW)

PRIORITY #2 – DELIRIUM

- Delirium Prevention through Safer Healthcare Now (SW)
- Hospital Elder Life Program (SW, HNHB, MH, Central, CE, SE)
- Delirium Screening (CW, MH)
- Inter-Professional Prevention of Delirium – IPPOD (TC)
- Maximizing Aging Using Volunteer Engagement – MAUVE (TC)
- Volunteers Assisting the Leisure Unique needs of our Elderly – VALUE (CE)

PRIORITY #3 – TRANSITIONS IN CARE

- CCAC Extenuating Circumstances Program (ESC)
- Blaylock Discharge Assessment Tool (SW, CE)
- Home Safety Leave of Absence, Discharge Liaison Team to LTC (SW)
- Quarterly Partnership Meetings with LTC/Retirement Homes (WW)
- Nurse Practitioners in LTC, Nurse Led Outreach Teams - NLOT, Nurse Practitioners Supporting Teams and Averting Transfers – NPSTAT, Emergency Mobile Nursing Service – EMNS (CW, MH, TC, Central, CE)
- Community Services Partnership, Retirement Home Partnerships for Transitional Care (MH, CW, TC, Central)
- All-Inclusive Seamless Services for Independence of Seniors' Today and Tomorrow – ASSIST (MH)
- Discharge Planning Meetings with LHIN and Community Services (MH)
- SPICCES Risk Screening (TC, Central)
- Community Consultation Support (TC)
- "Stepping Stone" Partnership for Transitional Care Beds (TC)
- Virtual Ward (TC)
- Post-Discharge Telephone Calls (TC, NSM, Champlain, NE)
- Inter-Professional Discharge Summary sent to Family Physicians (Champlain)
- Inter-Professional Model of Care for the Medical System (Central)
- Pre-Discharge Home Assessments with CCAC (Central)
- Discharge Planning Trial Passes with Occupational Therapy Support (CE)
- Assisting People Entering Nursing Home – ASPEN (CE)
- Family Health Team Partnership (CE, NSM)
- Better Outcomes for Older Adults through Safe Transitions – BOOST (CE)
- Discharge Package (CE)
- High Risk Screening Tool in ED (SE, NW)
- Transitional Discharge Model, Wendat Community Programs (NSM)
- Transition to Home Program (NE)
- Senior-Specific Components in Admission History (NW)

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Appendix C List of Abbreviations

ACE	Acute Care for the Elderly
ADL	Activities of Daily Living
ALC	Alternate Level of Care
AODA	Accessibility for Ontarians with Disabilities Act
ASSIST	All-inclusive Seamless for Independence of Seniors' Today and Tomorrow
CCAC	Community Care Access Centre
CE	Central East
CW	Central West
ED	Emergency Department
ESC	Erie St. Clair
FAQ	Frequently Asked Questions
GAIN	Geriatric Assessment and Intervention Network
HELP	Hospital Elder Life Program
HNHB	Hamilton Niagara Haldimand Brant
HR	Human Resources
LHIN	Local Health Integration Network
LTC	Long Term Care
MH	Mississauga Halton
NE	North East
NICHE	Nurses Improving Care of Healthsystem Elders
NRC	National Research Corporation
NSM	North Simcoe Muskoka
NW	North West
ON	Ontario
RGP	Regional Geriatric Program
SFH	Senior Friendly Hospital
SE	South East
SGS	Specialized Geriatric Services
SW	South West
TC	Toronto Central
WW	Waterloo Wellington

Ontario
Local Health Integration Network