

Toronto Central **LHIN**

Background Document:
**Senior Friendly Care
in Toronto Central LHIN Hospitals**

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Prepared for the Toronto Central Local Health Integration Network by the Regional Geriatric Program of Toronto

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Executive Summary

As a densely populated and highly diverse urban centre, the Toronto Central LHIN faces significant and unique challenges in providing quality and patient-centred care to an aging population.

Those 85 years of age or older are expected to increase in number by 48.5% between 2005 and 2015. Not only are seniors three times more likely to be hospitalised but their length of stay is also significantly longer than that of younger patients. Seniors account for 63% of all inpatient days in Ontario, and 76% of alternate level of care (ALC) days in the Toronto Central LHIN. In addition, a substantial body of evidence shows that the hospital stay itself makes seniors more vulnerable to complications and loss of functional ability, thereby contributing to longer hospitalizations and ALC. **One-third of frail seniors lose independent function as a result of hospital practices, half of whom are then unable to ever recover the function they lost.**

As outlined in its 2010-2013 Integrated Health Service Plan (IHSP), reducing emergency room (ER) wait times and ALC days are top priorities for the Toronto Central LHIN and the Ontario government. Enhancing the care of seniors in hospitals to increase their ability to transition safely from the hospital to the community is an essential component of an integrated, system-wide effort to reduce the time people spend waiting in emergency departments and ALC beds. Moreover, a systematic approach to improving hospital processes and the environment for seniors will contribute to hospitals' capacity to meet the quality and safety improvements required under the Excellent Care for All Act.

This background paper has been commissioned by the Toronto Central LHIN to support its Integrated Health Service Plan 2010-2013 priorities, including a commitment to **reduce the risk of functional decline for seniors while in acute care**. It describes the case for change and introduces a **Senior Friendly Hospital Framework**. The goal is to inform senior leaders in hospitals on how to modify the way care is organised and provided to older patients. Additionally, it is intended to emphasize the multiple dimensions of organizational change essential to achieve improved health outcomes for seniors. The Toronto Central LHIN will be stewards and leaders in this **systemic alignment of needs and resources** by supporting partner hospitals in adopting the Senior Friendly Hospital Framework and integrating measurable objectives into the hospital service accountability agreements.

There are various and well recognized systemic reasons for avoidable ER wait times and visits, ALC, and high re-admission rates among seniors, including lack of integration between hospitals and community providers and insufficient community based care options. However, hospitals play a pivotal role in the care of seniors and the impact of a hospital stay on an older adult's health is the one factor that is almost entirely within hospitals' span of influence.

In many Toronto Central LHIN hospitals, work is underway to improve the care for seniors; for example, through the creation of Acute Care of the Elderly (ACE) units and seniors oriented care pathways. In addition, recent funding investments in senior friendly community care have seen new programming introduced that is helping to improve care of seniors as they transition from hospital and while in the community (e.g., Home First, increased CCAC services).

A senior friendly approach to care in hospitals will complement and build on existing hospital efforts and community-based strategies underway to enable a system of care that keeps seniors well and functioning as independently as possible.

To enable hospitals to take a systematic, evidence-based approach, the Regional Geriatric Programs of Ontario have developed a five-domain framework for Senior Friendly Hospitals designed to improve outcomes, reduce inappropriate resource use, and improve client and family satisfaction:

- 1) **Organizational Support** reflects how the organization shows support for being a Senior Friendly Hospital through its organizational structures and processes.
- 2) **Processes of Care** reflects how the care and treatment of seniors take into account research and evidence regarding the physiology and pathology of aging, as well as social science research.
- 3) **Emotional and Behavioural Environment** reflects an organizational culture where staff interact with older patients in a respectful, supportive, and caring way.
- 4) **Ethics in Clinical Care and Research** reflects how care providers, researchers, and others ensure that ethical issues are fully addressed with elderly patients in the context of their care and in research studies.
- 5) **Physical Environment** reflects whether the organization's physical space is sensitive to the capacities of elderly patients and their visitors.

This Senior Friendly Hospital Framework provides a common pathway to engineer positive change which can be adapted to the unique context and realities of the Toronto Central LHIN. **While all five components of the Senior Friendly Hospital Framework are required for best outcomes, it is recognized that a staged approach to change maybe optimal.** The framework will therefore support the establishment of short, medium and longer-term change objectives and targets.

There are many benefits to becoming a Senior Friendly Hospital, the most obvious of which is the opportunity to prevent and mitigate the adverse effects of hospitalisation on older patients.

This work also complements current accreditation and patient safety goals; clinical practice initiatives such as the Registered Nurses' Association of Ontario's Best Practice Guidelines; capital reconstruction and accessibility plans; as well as the upcoming Excellent Care for All initiatives. Enhanced relationship-building is another indirect but significant benefit, as foundations often count seniors among their most consistent and generous benefactors.

The potential magnitude for cost-savings and cost-avoidance is very significant. For example, clinical efficiencies for in-patient geriatric services have been equated to **\$4,000 (USD) per patient** in some studies (Thorsten, 1999). A Canadian study assessing the impact of geriatric day hospitals indicated that **for every \$1 invested, \$2.15 was avoided** in future health care costs (Tousignant & Hebert 2003).

Concerted action to reduce the complications of hospitalisation such as delirium, fall-related injuries, and functional decline will have an impact on patient safety, patient flow and emergency wait times, while optimised discharge planning will have a measured affect on ALC days and

unnecessary readmissions to hospital. All the while, an improved emphasis on the emotional environment in which these care processes are provided should be reflected in improved patient/client satisfaction results. When considering cost effectiveness, an important but often forgotten notion is that the efforts to support the well-being of frail seniors within the health system will also serve to support other high-need patient populations, making these initiatives a true driver of value-based quality health care.

Care of the elderly is a core responsibility of hospitals that requires transformative change. Hospitals within the Toronto Central LHIN appreciate this need and many deliver high-quality, targeted seniors health programs and services. However, frail seniors occupy virtually all hospital units.

The systemic level of impact the LHIN is required to achieve can only be realised with a comprehensive and coherent strategy for seniors' services that is hospital-wide and founded on evidence-based standards.

1. Toronto Central LHIN Integrated Health Service Plan 2010-2013 and Seniors

The Toronto Central LHIN is responsible for the highest concentration of health services in Canada. Its area has a population of more than 1.2 million people representing an extremely diverse range of cultures, languages, socio-economic and educational backgrounds – all of which affects both the demand for, and delivery of health services. As seniors are the primary users of hospital services, systemic changes will be necessary in both hospitals and the broader health system to ensure the capacity and sustainability to respond to this elder care imperative.

While home to a high proportion of younger persons, the Toronto Central LHIN is also experiencing the challenges of meeting the needs of a rapidly aging population. Although the overall population is growing at a rate of 0.7 % annually, the population 75 years of age or older grew by an average annual increase of 4%, which resulted in a 20% increase from 2001 to 2006. As a result, seniors represent 14% of the overall population of Toronto Central LHIN, slightly higher than the provincial average of 13.6%. The rate of change is most dramatic in the population over 85 years of age, which is projected to increase 48.5% between 2005 and 2015. These changes are apparent in hospital utilisation, with seniors accounting for 39% of hospital admissions, and 76% of ALC days.

The Toronto Central LHIN has embarked on an ambitious agenda to transform the delivery of health services within its region.

A second Integrated Health Service Plan (IHSP-2) has been adopted to drive the transformation process for the next three years (2010-2013). Five strategic priorities have been identified:

1. Reduce ER wait times
2. Reduce ALC days
3. Improve access to services and outcomes for people with diabetes
4. Improve access to services and outcomes for people with mental illness and/or addictions
5. Enhance value and affordability of health care services

As part of this integrated plan, multiple intervention strategies will be implemented to build and strengthen the geriatric capabilities of the Toronto Central LHIN health system. As might be expected, the majority of the initiatives targeted to seniors are aligned with the ER and ALC strategic priorities of the LHIN.

Priorities 1 and 2: Reduce emergency room wait times and alternate level of care days	
To accomplish these priorities, the Toronto Central LHIN plans to meet the following initiatives over the next three years:	
<i>Initiative #1</i> Standardize referral and intake processes to improve the flow of patients to and within community programs.	<ul style="list-style-type: none"> • Expand the standard intake and referral process throughout community agencies that provide services to seniors. • Coordinate referrals to community support services in neighbourhoods using the Community Navigation and Access Project model, which enables patients and clients to get all the services they need through one point of access. Hubs will be identified that will provide access to coordinated services to support aging in place and the needs of caregivers.
<i>Initiative #2</i> Enhance community based programs and services to support patients at home.	<ul style="list-style-type: none"> • Expand and enhance intensive case management programs. These programs promote independence and quality of life by coordinating appropriate services and providing constant support to clients. Enhanced intensive case management services will focus initially on at-risk groups such as frail seniors and clients with addictions. • Enhance supportive housing services to support newly identified at-risk clients. • Expand convalescent care to ensure seniors who are transitioning back to their homes and communities are able to function in their daily lives
<i>Initiative #3</i> Improve hospital processes to increase capacity in the emergency department.	<ul style="list-style-type: none"> • Increase efforts to identify high-risk seniors to ensure they receive the appropriate services after they are discharged from hospital. • Enhance care of seniors within hospitals to increase their ability to transition safely from the hospital and into their community. Examples of enhanced care may include medication safety, wound prevention, assistance with continence, walking and nutrition.

Additionally, as a component of the ER/ALC strategy, the LHIN has committed to **‘identify priorities for reducing risk of functional decline for seniors while in acute care’** and ultimately, to incorporate these priorities into hospital accountability agreements in 2011/12. This is a truly transformational priority in relation to hospital care for seniors, and positions the Toronto Central LHIN to be a leader in hospital services for seniors in Canada.

Most often, hospital planning and policy focus on the consequences of care for older adults and ALC pressures, rather than their root causes. While the LHIN has clearly recognised the significance of timely access to appropriate community care and support as a pillar of senior’s health services, their commitment to recognise the hospital experience of older patients as a contributing factor in ALC pressures is commendable. Indeed, the potential to align these strategies to achieve a cumulative impact affecting both hospital and transitional care for the elderly is most significant.

Many, if not all, of the hospitals within the Toronto Central LHIN appreciate the need and deliver targeted geriatric and seniors health programs and services. However, frail seniors occupy virtually all hospital units. The systemic level of impact the LHIN is required to achieve can only be realised with a comprehensive and coherent strategy for seniors’ services that is hospital-wide. This

background report has been commissioned by the Toronto Central LHIN to support its Integrated Health Service Plan 2010-2013 priorities.

The purpose of the document is to inform hospital senior leadership teams of the need to modify how care for older patients is organised and delivered, and to introduce a framework to guide organizational changes to improve quality, safety and health outcomes for older patients in hospitals.

2. Older Patients & the Hospital Experience

The greying of acute care is occurring at a rapid rate. Seniors are three times more likely to be hospitalised than the population as a whole and their length of stay is significantly longer. They account for 63% of all inpatient days in Ontario. Between 1961 and 1992, per capita hospital use in Canada for all other age groups declined, while that for those 75 years of age or older increased 23% (Fact Book on Aging, 2001). This pace of change has not been mirrored by changes tailored to meet the needs of older patients. Given the relatively rapid growth of the older populations in Toronto Central LHIN, pressures on hospital resources can only increase.

It is generally acknowledged that, by design, the priorities of most hospital staff focus on rapid, effective diagnosis and management of serious illness or major operative procedures (Calkins 1999). However, there is now widespread agreement that for most older patients hospitals provide a difficult, if not hazardous experience (Boult 1999) characterised 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 both 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.

2.1 Hospitalisation as a Pivotal Event

For older patients, the benefits of acute hospital care is often compromised by the experience of hospitalisation itself, which presents risks for adverse events and functional loss that can have a significant impact on an older person's discharge trajectory. The greater complexity of care needs of older adults increases the risk for preventable adverse outcomes, and complicates the transition out of hospital (Parke 2010). 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 creates a set of complex physical, social and functional consequences that are not well-served by the episodic focus of acute care (Fisher 2002). With this clinical complexity, older patients frequently present with atypical symptoms of disease. Older patients may also be slower, less reliable historians, and those with sensory or communication deficits are at greater risk of inadequate and incorrect assessment in acute care (Adelman 2000). 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 (Kapp 2001). All of these factors contribute to misdiagnosis, delayed diagnosis, or under-diagnosis, and 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.

For many seniors, hospitalisation can become a pivotal event (Inouye 1993); either adding years or quality to their lives or placing them at risk of losing a great degree of independence. Hospital practices may cause significant harm to the elderly and include: prescribed immobility, unfamiliar surroundings, lack of sleep, under-nutrition, medications and interventions that predispose them to falls and nosocomial infections (Tsilimingras 2003). The outcomes are even worse for older patients entering hospital with pre-existing cognitive impairment (Sands 2002).

Although older patients may eventually recover from some of these losses, the functional decline caused by hospitalisation is not readily reversed (Sager 1999). The outcomes of these functional losses include increased length of stay, extended rehabilitation, increased community care requirements, hospital re-admission, and a **13.9 fold increase** in the likelihood of nursing home placement (Sager 1998, Baldacci 2000).

While some regard the disconnect between the care needs of older patients and current hospital practices as deficiencies, others view it as a complex interaction of the vulnerability of older patients with the high demand environment and inflexible systems of care delivery (Parke 2010). This perspective suggests an approach which integrates evidence-based care of the elderly, while building on the tremendous existing strengths of the hospital care system.

2.2 Patient Safety – Age and Adverse Events

It is important to consider the greater burden of iatrogenic complications and medical errors borne by elderly patients. The Harvard Medical Practice Study indicated that seniors are at twice the risk of adverse events (Brennan et al. 2001). The Canadian Adverse Events Study also reported that patients with adverse events were significantly older than those without (Baker et al. 2004).

- As seniors are by far the largest users of prescription medication, it is not surprising that adverse drug events are the most common adverse events amongst the elderly. Although the reported incident rates for adverse drug interactions amongst seniors is between 5.8% and 14.8%, this increases in proportion with the number of medications a patient is taking. “When two drugs are prescribed, the potential for interaction is 6%. The potential increases to 50% for five drugs and 100% when the number of prescribed medications reaches eight.” (Swift 1998)
- Given that their length of stay is almost twice that of the general population, seniors are more exposed to nosocomial infection risk. Older patients have been reported as accounting for 50% of all hospital-acquired infections (Fisher 2002).
- Hospital-acquired delirium, particularly post-operative, is a disease of the elderly with a prevalence of up to 40.8% (Inouye 2006). This contributes to increased lengths of stay, cost of care, mortality and morbidity.
- Surgical complication rates for the elderly are twice that of other patients. Elderly patients make up half of all surgical emergencies and three-fourths of all operative deaths (Rothschild et al. 2000).
- It has also been widely acknowledged that older patients are at the highest levels of risk for falls (Mahoney 1998). Unintentional injury, most often caused by a fall, is the sixth leading cause of death among seniors.

The reasons for the high incidence of adverse events in hospitalised older patients are admittedly complex. The presence of multiple illnesses, polypharmacy, limited compensatory reserves, hospital

practices, and lack of continuity of care have been identified as contributing factors. The challenge for hospital teams to recognise and manage common geriatric syndromes such as falls, delirium, incontinence, under feeding and pressure ulcers has also been identified as a significant factor (Tsilimingras et al. 2003). The high rates of mortality in hospital associated with these syndromes, and the fact that many are preventable, argue in favour of a systems approach to care.

“It is not the aging of our population that threatens to precipitate a financial crisis in health care, but a failure to examine and make appropriate changes to our health care system, especially patterns of utilisation.” (Dalziel 1996)

2.3 Mitigating the Adverse Effects of Hospitalization: What Works

The potential to reverse or mitigate the adverse effects of hospitalisation on older patients has been well-researched within the context of interdisciplinary geriatric teams at the program or unit level. Geriatric Assessment Units, where assessment and interventions are managed within the parameters of well trained geriatric teams, demonstrate improved outcomes in relation to lengths of stay, placement, level of function and mortality (Calkins 1999).

Brief summary of geriatric research studies by outcome:

Benefits	Evidence-Based Outcomes	References
Improved Patient Outcomes	Reduced loss of function associated with hospitalisation	Baztan 2009; Caplan 2004; Cohen 2002; Stuck 2002.
	Increased likelihood of living at home	Baztan, 2009; Challis, 2004; Mion 2003.
	Improved physical and mental health, vitality, social function,	Counsell 2009; Caplan 2004; Cohen 2002; Bernabei 1998.
	Improved continuity of care	McCusker 2006.
	Improved diagnoses	Challis 2004.
	Reduced loss of function associated with hospitalisation	Baztan 2009; Caplan 2004; Cohen 2002; Stuck 2002.
Increased clinical efficiencies	Reduced hospital days	Thorsten 1999; Brymer 1995.
	Reduced placement in long-term care	Challis 2004, Stuck 1995; Applegate 1990.
	Cost-savings	Tousignant & Hebert 2003; Thorsten 1999; Bernabei 1998.
	Improved clinical decision-making	Challis 2004;

Given the resource intensity often represented in the population of frail older patients, the magnitude of potential cost-savings or cost-avoidance is significant. Clinical efficiencies for in-patient geriatric services have been equated to **\$4,000 (USD) per patient** in some studies (Thorsten, 1999). A Canadian study assessing the impact of geriatric day hospitals indicated that **for every \$1 invested, \$2.15 was avoided** in future health care costs (Tousignant & Hebert 2003). While the nature of both the interventions and patient populations affect the level of replication across jurisdictions, they provide useful direction for the scale of impact on clinical efficiency.

In an effort to improve the acute phase of care for older persons, some hospitals have established Acute Care of the Elderly (ACE) Units. Appropriately modified environments include simple

adaptations such as larger wall clocks, uncluttered hallways, handrails, door levers and other senior-friendly environmental designs. In the ACE unit, geriatricians and geriatric nurse clinicians work hand in hand with internal medicine and interdisciplinary acute care teams, integrating both acute and rehabilitative principles of geriatric care. Improved outcomes have been realised in relation to **level of function, placement and overall cost of care**. However, it should be noted that planned follow-up and transition planning are required for these benefits to be sustained (Covinski et al. 1997).

Another innovation, developed at the Yale University School of Medicine under the leadership of Dr. Sharon Inouye, is the Hospital Elder Life Program (HELP). The program is intended to prevent delirium and functional decline in hospitalised seniors, and is integrated into existing hospital services. Expenditures for delirium have been estimated at \$16,303 to \$64,421 (USD) per patient. Delirium also contributes to subsequent system level costs in relation to increased need for both long-term care and home care. The program, now replicated across numerous sites in the United States and Canada, has demonstrated positive outcomes in the prevention of delirium and functional decline, and has also achieved cost-efficiencies in both acute and long-term care settings (Inouye 2008).

*Using the example of a community hospital implementing an adapted version of the HELP program in the United States, rates of delirium dropped **14.4%**, decreasing costs on a **40 bed unit** by **\$626,261 over a six-month** period (Podrazik 2008).*

The HELP program was implemented at Hamilton Health Sciences in 2005 under the leadership of the Regional Geriatric Programs' interdisciplinary clinical team. It is currently operating on five floors at two hospital sites with a clinical team of four staff and 100 volunteers. The program was successful in replicating the outcomes of the HELP program. Based on results from the first 197 patients treated in the program, the incidence of delirium and functional decline dropped to 4%, call bell use was reduced, and patient and family satisfaction was uniformly rated as high.

3. The Case for a Systems Approach to Hospital Care for Older Patients

While specialised geriatric programs demonstrate the potential to intervene and more effectively manage hospital care for older patients, the scope of this impact is limited by other barriers, such as inadequate transitional care for this patient population. Other systemic barriers include the limited academic preparation and training of health care professionals in care of the elderly, the pervasiveness of ageism or negative societal attitudes, and the constraints of hospital design and departmental structures, all of which conspire against age-appropriate hospital care (Parker 2006).

Notwithstanding the recognition of care of the elderly as a core responsibility of hospitals and the real potential to improve quality and utilisation outcomes, the combined effect of multiple programs will be muted in the absence of a framework to align them. To achieve hospital-wide and system level outcomes, there must be an emphasis on aligning practices which integrate geriatric principles into all aspects of hospital care. Indeed, the Ontario Health Services Restructuring Committee (2000) recommended that "all hospitals take steps to further develop their geriatric capabilities."

“No single initiative or set of unaligned projects will likely be enough to produce system-level results.....the development of a system for execution of a portfolio of projects aligned with the strategy that produces and sustains results is a vital component.” (Nolan, IHI 2007)

The concept of the Elder Friendly Hospital in Canada evolved initially within the Vancouver Island Health Authority in the 1990s under the clinical leadership of Belinda Parke. The Elder-Friendly Hospital Initiative recognised the adverse effects of hospitalisation in older patients, and committed to predict and prevent remediable problems associated with hospitalisation of older patients. A variety of strategies were proposed to narrow the gap between what older patients need and what the hospital experience offers. These strategies included early identification of risk factors (Elder Alerts) intended to “prevent the preventable, reverse the reversible”, hospital-wide clinical education programs, properly equipped environments, and enhanced community partnerships.

In Ontario, the Regional Geriatric Programs of Ontario began exploring ways to support changes in hospital care of the elderly. Building upon the work of the Vancouver Island Health Authority and guided by interdisciplinary knowledge translation principles (Logan & Graham 2004), a Senior Friendly Hospital Framework evolved.

“How systems of care delivery are structured can have a major impact on their relative efficiency and on the quality of care provided to individuals.” (Hollander 2008)

As a foundation for the framework, the Regional Geriatric Programs of Ontario integrated the Principles for Medical Care of Older Persons endorsed by the Canadian Medical Association (2000). These principles could in turn be used to develop or evaluate policies, practices and programs for older patients. The Canadian Medical Association principles can be summarized as follows:

1. All seniors, independent of location, should have access to services of a clinically appropriate nature. An acceptable standard of clinical care should not be denied on the basis of age or disability.
2. Health promotion and illness prevention should be integrated into all levels of care – including tertiary – to maximize functional independence and promote wellness.
3. Special consideration must be given to the needs of the frail elderly. They require rapid access to an integrated range of specialized health care services.
4. High quality interdisciplinary teams must be available. Education in the care of older persons is necessary to enable high quality care. Education must be provided to staff, health planners, patients and families.
5. The particular ethical and legal concerns in caring for older patients including capacity to make decisions, informed consent, and communication of and respect for treatment preferences, must be adequately addressed.
6. Effective planning for the care of seniors must stress the application of the findings of research and continual evaluation of service delivery to define best practices.
7. Research into improving the health care of older persons needs to be promoted, conducted and applied.

While our understanding of integrated community-based care systems for older persons has advanced significantly (Hollander 2008, MacAdam 2008), approaches to equip the hospital sector to

respond to the needs of its primary patient population remain in their formative stages. Traditionally, hospitals have relied heavily on in-service education to change individual practice; however, it is increasingly recognised that the practice environment is influenced by more than the clinical knowledge of the interdisciplinary team. Organizational alignment of programs and innovations is a critical component of health care transformation and quality of care. The Institute for Healthcare Improvement's elements for strategic improvement centre on the notion of Will, Ideas and Execution, and reinforce the importance of an overarching framework to integrate multiple interventions around a common strategy (Nolan). The Senior Friendly Hospital Framework is intended to fulfill this function in relation to improvements in the hospital care of the elderly.

4. Creating a Common Pathway – A Senior Friendly Hospital Framework

The advantage of applying a framework to guide organizational change is that, in addition to providing a common pathway essential to achieve organizational and system level changes, it can be adapted to the unique context and realities of organizational challenges and opportunities. In particular, consideration must be given to recognise the primary mission of hospitals and protect what is being done well while integrating principles and processes for care of the elderly – all while recognizing the unique culture of each hospital across the LHIN.

The Senior Friendly Hospital Framework developed through the Regional Geriatric Programs of Ontario is a systematic approach consistent with the Canadian Medical Association principles on Care of the Elderly and grounded in principles of knowledge translation and organizational change that promotes evidence-based practices in geriatric care in hospital settings. The foundation of the framework encompasses five inter-related building blocks or domains intended to guide the organizational transformation to more age-appropriate hospital care for older patients.

The goals of implementing the Senior Friendly Hospital Framework are to improve patient outcomes, reduce inappropriate use of health care resources, and improve patient and family satisfaction.

The combination of provincial investment in capital infrastructure for hospitals and emerging legislative requirements to assure accessibility align effectively with the Physical Environment element of the Senior Friendly Hospital Framework. As a result, a number of hospitals in Ontario looked to the published guidelines on elder friendly design to integrate into both capital reconstruction and Accessibility Plans. Similarly, many hospitals working with the provincially funded Registered Nurses' of Ontario's Best Practice Guidelines were able to implement provincially developed practice guidelines for care of the elderly, consistent with the Processes of Care.

Senior Friendly Hospital Framework: Regional Geriatric Programs of Ontario

- | | |
|---|---|
| 1. Organizational Support | Does the organization show its support for being a Senior Friendly Hospital in its' organizational structures and processes? |
| 2. Processes of Care | Does the care and treatment of seniors take into account research and evidence regarding the physiology and pathology of aging, as well as social science research? |
| 3. Emotional & Behavioural Environment | Does staff interact with older patients in a respectful, supportive and caring way? |
| 4. Ethics in Clinical Care & Research | Do care providers, researchers and other ensure that ethical issues are fully addressed with elderly patients or research subjects? |
| 5. Physical Environment | Is the physical environment sensitive to the capacities of elderly patients and visitors? |

4.1 Organizational Support

Does the organization show its support for being a Senior Friendly Hospital in its' organizational structures and processes?

It is essential for leadership at the highest levels of the organization to demonstrate its commitment to the change process for senior friendly care. Examples of demonstrated organizational commitment include:

- Explicit commitment at the level of senior leadership and governance
- Identified organizational champions
- Endorsement of the Canadian Medical Association Principles for Care of the Elderly
- Relevant organizational policies and procedures
- Designated committee structures such as interdepartmental geriatric or seniors' advisory committees supported with age-sensitive indicators
- Recruitment of staff trained and knowledgeable in care of the elderly
- Corporate orientation, ongoing in-service education programs

4.2 Processes of Care

Does the care and treatment of seniors take into account research and evidence regarding the physiology and pathology of aging, as well as social science research?

This element identifies evidence-based or best-practice guidelines that can be adapted to the needs of specific organizations. Processes of care become enablers for providers to deliver the most up-to-date care to seniors possible. To achieve this, it is recognised that information must be concise, easily understood, and conveniently accessible. A clinical framework for acute care of the elderly in the United States, where approximately 50% of acute care beds are occupied by seniors, identifies four high-impact elements of hospital care of the elderly:

1. high-risk screening for vulnerable patients;
2. avoiding the hazards of hospitalisation, with a focus on delirium, falls, use of indwelling catheters, deconditioning, adverse drug reactions, and pressure ulcers;
3. improving palliation and end-of-life care issues; and

4. improving transitions of care (Podrazik 2008).

Guidelines in the following areas have been identified as sufficiently developed to be implemented without further research or qualifications: falls prevention, skin care, mobility, and pain and delirium management. The Best Practice Guidelines produced by the Registered Nurses' Association of Ontario are an example of resources available to advance the implementation of processes of care, consistent with the overall Senior Friendly Hospital Framework (<http://ltctoolkit.rnao.ca/>). Other sources of senior relevant hospital care guidelines include the Nurses Improving Care to Health System Elders (NICHE, <http://www.nicheprogram.org/>) and the Australian Best Care for Older People Everywhere Toolkit (<http://www.health.vic.gov.au/older/toolkit/index.htm>).

Hospitals choosing to move forward with the implementation of evidence-based care of the elderly processes will need to first recruit or designate geriatric and gerontological specialists to provide clinical leadership. The needs of seniors are complex. No single profession has all of the expertise required to address the multiple medical, functional and social issues that invariably arise. It will be the role of these geriatric leaders within the organization to champion interprofessional education and clinical practice in parallel to the guiding principles described in HealthForceOntario's Interprofessional Care: A Blueprint for Action in Ontario (www.healthforceontario.ca/upload/en/whatishfo/jpc%20blueprint%20final.pdf). Greater efficiencies and improved quality can be realised in the care of frail seniors by optimising these teamwork processes. The Regional Geriatric Programs of Ontario, in collaboration with the Centre for Research in Aging and Health and the North East Specialized Geriatric Services, have created an online resource, the GiiC Toolkit, to provide meaningful help in realising this potential (www.giic.rgps.on.ca).

The implementation of high-risk screening and assessment protocols to support the early identification of older patients more vulnerable to the adverse effects of hospitalisations and interventions to prevent or reduce these risks have been identified as a key component of care of the elderly within hospitals (Inouye 2006, Parke 2004).

Subsequent to screening, and dependent upon targeted risk factors and organizational readiness, hospitals may adopt and implement clinical protocols targeted to reduce specific geriatric syndromes such as delirium, falls or pressure ulcers. Alternatively, consideration can be given to implementing more comprehensive programs ranging from specialised geriatric assessment and treatment units to Acute Care of the Elderly (ACE) units and gerontological nursing programs such as HELP or NICHE referred to previously. Increasingly, consideration has been given to integrate geriatric screening into emergency departments through Geriatric Emergency Management (GEM) programs. It is worth noting that, in addition to achieving improved health outcomes, a number of studies also identify improved clinical efficiencies and cost reductions resulting from more age-appropriate treatment and intervention (Rubin et al. 2006, Nikolaus 1999).

Another key feature attributed to Senior Friendly Hospital care is that of transition, or discharge planning. Older patients undergoing transitions are in an extremely vulnerable state, experiencing a lack of preparation, sense of abandonment and overall disregard for their preferences (Coleman 2005). Strategies to enhance patient-centred transition planning have been associated with reduced recidivism (Coleman 2005). It is most significant that the Toronto Central LHIN has concurrently identified initiatives intended to reduce functional losses associated with hospitalisation, while at

the same time, committing to improved intake and referral processes and the enhancement of community care and support services. This creates significant potential to align these initiatives with the implementation of a Senior Friendly Hospital strategy.

Hospitals looking to incorporate care of the elderly screening, treatment and intervention processes into their quality and patient safety programs should carefully consider the anticipated scope of impact they expect to achieve, as well as organizational readiness to support implementation.

- High-risk screening for vulnerable patients
- Avoiding the hazards of hospitalization
- Adoption of existing best practice guidelines for geriatric care with an emphasis on interprofessional approaches
- Implementation of geriatric or gerontological programs
- Safe, sustainable discharge practices

4.3 Emotional & Behavioural Environment

Do staff interact with older patients in a respectful, supportive and caring way?

While providing care centred on patients' needs and expectations is a key factor in quality health care, the unfamiliarity of the hospital environment combined with the traditional structure of communications with health care providers often conspire to leave the needs and concerns of older patients unspoken (Bergeson 2006, Calkins 1999). Additionally, the influence of ageism and its negative stereotypes provide an added bias and can lead to discriminatory health care practices (Butler 2008).

A range of program planning and communication strategies have been suggested to promote a more respectful and engaging level of involvement of older persons and their families in health care decision-making. These can include professional development to offset the negative stereotypes of aging through to individualised approaches to care planning; community education to better prepare older adults for the hospital experience; as well as alternative strategies to give voice to the needs and expectations of older patients in strategic and program planning (Parke 2004).

The impact of these strategies can be assessed through patient feedback and surveys. Although patient satisfaction has been a key driver in quality management in hospitals in Ontario, few have begun to explore the differences in the patient experience by age cohort. While there are inherent limitations in survey methodology, which are further compounded by the perspective of family caregivers, it is recommended that age-sensitive patient satisfaction measures are incorporated into quality management strategies. In particular, hospitals are able to generate National Research Corporation Picker results specific to the experience of patients 75 years of age or more, and examine particular dimensions of the patient experience. These would be seen as a complement to staff education initiatives related to care of the elderly.

- Respect and courtesy of staff
- Information sharing and involvement in decisions about plans of care
- Individualized approaches to patient and family
- Cultural and gender sensitive programming
- Advisory structures and processes for older adults and families

- Older patient and family satisfaction surveys used in program planning

4.4 Ethics in Clinical Care & Research

Do care providers, researchers and others ensure that ethical issues are fully addressed with elderly patients or research subjects?

The complexity of competency and end-of-life issues which frequently arise in clinical decision-making related to care of the elderly demand a thoughtful and consistent approach to the ethical dimensions of health care delivery for older patients at all levels, from systems planning to the bedside. While there is much room for development in this area, practitioners interacting with older patients are faced with ethical dilemmas on a daily basis. Many hospitals have moved forward with organizational policies to address certain aspects of clinical decision-making. These include competency and capacity assessment, the establishment of policies for advance directives, as well as mandated privacy and confidentiality policies.

- Thoughtful discussion of treatment or palliative options
- Respecting the autonomy and self determination of older adults
- Competency and capacity assessment policy and procedures
- Dispute resolution procedures
- Use of advanced directives
- Privacy and confidentiality

4.5 Physical Environment

Is the physical environment sensitive to the capacities of elderly patients and visitors?

A comprehensive literature review of senior friendly design guidelines was undertaken and published as a preliminary component of the Senior Friendly Hospital Framework (O’Keefe 2004). These were subsequently translated into environmental audits that a number of hospitals used to inform capital construction and accessibility planning. The guidelines are comprehensive and cover all aspects of the built environment from parking and way-finding to decor, fixtures and furniture. In some instances, hospitals have aligned purchasing practices to ensure new furniture purchases adequately meet the needs of older patients.

More recently, these design guidelines have been adapted for the emergency department, as a complement to GEM programs, as well as the specific needs of older patients with dementia.

- Way finding
- Visual aspects of the environment
- Physical space and accessibility
- Sensory comfort
- Furniture

In addition, Parke and Associates at the Fraser Health Authority have published a complementary set of design guidelines with input from an interdisciplinary design team, called *CodePlus: Physical Design Recommendations for an Elder Friendly Hospital* (Parke and Friesen, 2008)

<http://www.fraserhealth.ca/media/CodePlus%20-%20Physical%20Design%20Components%20for%20an%20Elder%20Friendly%20Hospital.pdf>

5. The Way Forward in Toronto Central LHIN

“...we can’t get them out, because we fail them in the beginning.”

Toronto Central LHIN Hospital Administrator

ALC pressures in hospitals have long been recognised as a symptom or consequence of health systems inadequately aligned with the needs of an aging population. While much of the focus for resolving these pressures has quite rightly been placed on community and long-term care sectors, the Toronto Central LHIN acknowledges that the hospital experience of older patients in itself can contribute to outcomes that constrain safe and sustainable discharges and precipitate ALC pressures. It equally acknowledges the weight of evidence in support of more senior friendly hospital care that can prevent or reduce the negative consequences of hospitalisation. The LHIN is committed to working with its hospitals and their community partners to improve quality of care and achieve health outcomes that seniors deserve and that society requires.

The Toronto Central LHIN recognises that care of the elderly is part of the core responsibilities of hospitals, and acknowledges that substantive transformative changes are required to adequately prepare hospitals to meet the needs of older patients. The Senior Friendly Hospital Framework is a roadmap for quality improvement for the hospital care of older patients and serves as a potential resource to achieve the identified priorities of the Toronto Central LHIN to reduce lengths of stay and functional loss associated with hospitalisation, and to achieve system level outcomes. A critical first step in the transformational process is the expressed commitment of the Toronto Central LHIN to support partner hospitals in this journey, and to mandate measurable objectives into their implementation plans.

This Senior Friendly Hospital Framework provides a common pathway to engineer positive change which can be adapted to the unique context and realities of the Toronto Central LHIN. **While all five components of the Senior Friendly Hospital Framework are required for best outcomes, it is recognized that a staged approach to change maybe optimal.** The framework will therefore support the establishment of short, medium and longer-term change objectives and targets.

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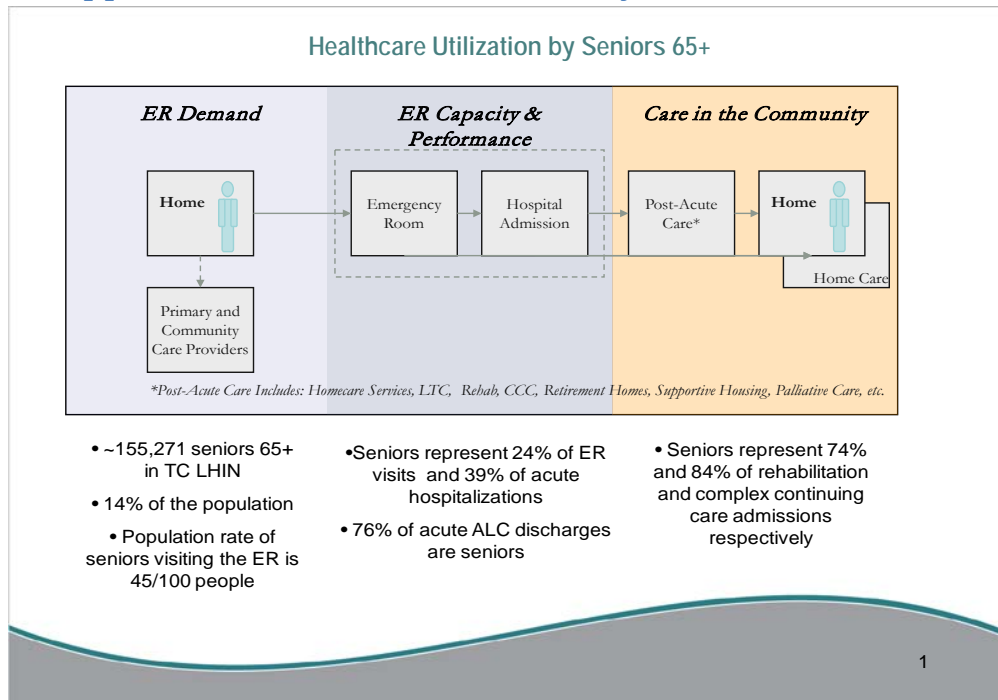
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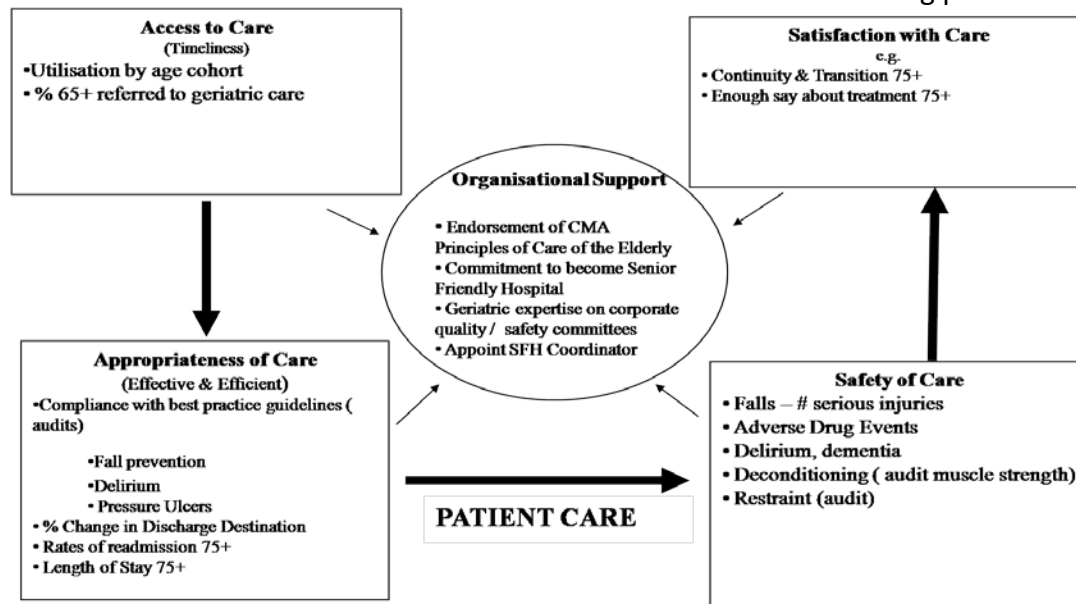
7. Appendices

7.1 Appendix: Health Care Utilisation by Seniors in TCLHIN



7.2 Appendix: Evaluation Framework

An evaluation framework has been developed to monitor progress and performance in relation to the Seniors Friendly Hospital strategy, consistent with dimensions of quality integrated into many existing hospital quality plans. The intent is that hospitals integrate specific age-sensitive quality indicators into their organizational quality plans. Depending upon the extent to which hospitals in Toronto Central LHIN are participating, additional measures may be derived from the Health Outcomes for Better Information and Care measures related to nursing professional practice.



7.3 Appendix – Detailed Environmental Checklist

(Adapted from Frank et al, 2007; Parke and Friesen)

Lighting

- Does lighting provide a glare free environment?
- Is their sufficient lighting in areas for reading and task completion, as well as in flooring, walkway, ramp, wayfinding signage, and stairway areas?
- Are abrupt changes in lighting, from natural and artificial sources, avoided?
- Are there nightlights inside and outside of patient washrooms?
- Can patients control the lights in their own areas themselves?
- Are windows glazed or fitted with (a) a shading device to reduce sunlight/glare, and (b) a reflective material to increase sunlight penetration into deeper areas?

Décor/Colour

- Are warm colour tones used, with minimal blues, greens, and pastel tones?
- Are bold patterns and flecking avoided on flooring, walls, equipment, and furniture?
- Are doors in patient areas highlighted by using a contrasting colour, while doors to unwanted areas (such as exit doors or doors to out-of-bound areas) are camouflaged by using a similar colour as surrounding surfaces?
- Are floors, walls, and handrails made highly visible by using contrasting colours?
- Does artwork have clear and realistic definitions (no abstracts) and a glare-free finish?

Noise/Acoustics

- Are heating/ventilations systems of the silent/quiet type?
- Is the use of overhead pages minimized or done at a quiet volume?
- Are there measures to reduce noise from conversations at the nursing station?
- Are there measures to reduce noise between patients, such as earphones for music/television and the availability of single person rooms?
- Are there talking aids, such as hearing amplifiers, available?
- Are double glazed windows installed?
- Are patient room doors solid core with sound stripping installed?

Flooring/Walls

- Is flooring material non-glare, non-slip, and acoustically minimizing?
- If carpet is used, is it low-pile with either a firm underpad or no underpad?
- Is flooring material consistent throughout the unit/area to avoid changes in flooring type or colour?
- Do walls have a matte, non-glare finish?
- Is wall texture behind handrails smooth and non-abrasive?
- Are floors, walls, and baseboards clearly defined by using contrasting colours?

Hallways/Doors

- Are hallways and doorways wide enough and clutter-free so as to be wheelchair accessible, including corners which accommodate the turning radius of a wheelchair?
- Are doorsteps and raised thresholds eliminated or kept to minimal height?

- Are doors equipped with lever style handles?
- Are there seating areas at regular intervals of long hallways/passageways?
- Are entrances equipped with automatic sliding doors with a longer delay (4-6 seconds)?

Bedrooms

- Is there a direct sightline and clear path from bed to washroom?
- Are call bells able to be fixed to the bedside, and do they have large, easy-to-use buttons? Are they remote voice-activated?
- Are telephones within easy reach of patients?
- Are there bedside light switches with clear labels and large, easy-to-use switches?
- Are there large diameter clocks and large calendars mounted where patients can easily see them from bed?
- Is there a patient orientation board, with regularly updated information?

Washrooms

- Do washroom doors swing outward, and are doorways wide enough for a wheelchair/walker?
- Does the space inside the washroom allow for a full wheelchair turning radius?
- Is there at least one wheelchair accessible vestibule in public washrooms?
- In public washrooms, are handles on vestibules D-shaped and mounted horizontally on the inside?
- Are higher toilets (460mm) or raised toilet seats available in all washrooms?
- Do toilets in patient areas have space for an above-toilet commode?
- Do all toilets have back support, and have flushing mechanisms (auto-flush if possible) and toilet paper dispensers in easy reach (not behind the seating position)?
- In public washrooms, is there an appropriate chair available for caregivers or older adults using walkers?
- Are wash basins mounted to allow for wheelchair access?
- Are sink faucets equipped for a controlled water temperature?
- Do tubs/showers in patient washrooms a non-slip floor finish?
- Are there walk-in showers available on patient areas that can accommodate a commode/shower chair?
- Are bath/shower controls accessible from wheelchair height and operable with one hand?
- Are toilets, urinals, showers, and tubs equipped with grab bars?
- Are towel dispensers, hand dryers, and other accessories positioned at an appropriate height/location for wheelchair access?

Handrails

- Are handrails installed on both sides of stairways and hallways, and on at least one side of ramps?
- Do handrails extend between landings on stairways, and an appropriate distance beyond the end of ramps and stairways?
- Are handrails of a consistent diameter, have a non-slip texture, at an appropriate height, and equipped with a tactile signal 100mm before the handrail ends?
- Are handrails installed on both sides of all elevator cabins?

Walkways, Ramps, and Stairways

- Are walkway, ramp, and stairway surfaces slip-resistant?
- Are long walkways and ramps broken up with seating areas?
- Are walkways and ramps wide enough for two wheelchairs to pass and do they have sufficient manoeuvring space around corners?
- Are grate and grid openings small enough so that wheelchairs, walkers, and canes will not become stuck?
- Are ramps and stair risers in a different contrasting colour from level surfaces, and are the edges of ramps and stair risers clearly identified with a yellow strip or contrasting colour?

Wayfinding, Signage, and Orientation

- Are signs as large as possible, uncluttered, use non-technical language (appropriate to a sixth grade reading level) and include simple, explanatory graphics?
- Are “You are here” maps and/or appropriate handouts provided at entrances, receptions, and information areas?
- Are directional signs posted consistently at all major intersections?
- Is colour coding incorporated to facilitate wayfinding, with a standard colour and texture throughout hospital grounds?
- Are wayfinding signs in high contrast colours with light letters on dark, matte-finish backgrounds?
- Is the font size at least 16mm high on small signs, and 40 mm high on large signs, with tactile lettering?
- Are signs at an appropriate height for both wheelchair and upright users?
- Are signs posted at high profile places, meaningful decision points, and at all key intersections?
- Are large, appropriately coloured signs indicating floor number posted outside of each elevator?
- Are functional areas clearly demarcated by colour and identifying features?
- Are hallways free of clutter to allow unimpeded pathways wide enough for a wheelchair/walker and a caregiver?
- Are there volunteer guides available to accompany clients to destinations?

Parking/Accessibility

- Are there a sufficient number of wheelchair accessible parking spaces located nearby and with direct routes, with a grade of less than 1:20, to each hospital entrance?
- Are some wheelchair accessible parking spaces equipped with a locking mechanism to block wheelchairs during transfer?
- Are safe routes to entrances well lit and marked with signage?
- Is there a sheltered drop off/pick up area leading to main entrances?
- Is there adequate parking for scooters?

Equipment

- Are there marked areas for public use assistive devices such as wheelchairs and scooters?
- Are there a variety of mobility devices available for patient use?
- Are public telephones at an accessible location with available seating?
- Are patient/public telephones equipped with large push buttons with large, contrasting numbers/letters, and a volume control and/or plug-in hearing aid?
- Are treatment tables height adjustable?

- Are blanket warmers available in patient care areas?
- Are wandering alert systems installed in needed specialty patient units?
- Are beds height-adjustable to a low height (460mm low point), and equipped with four split aid rails which cannot fold to the floor?
- Are pressure reducing mattresses and seating cushions available?
- Are full, partial, and/or ceiling lifts available with sufficient space between beds and furniture for them to be used safely?
- Is there sufficient space between beds and furniture to accommodate a full wheelchair turning radius?
- Are controls for equipment and devices easy to reach from patient beds?
- Do handout materials have large print (minimum 14 point font?)

Furniture

- Is there seating available, with full depth armrests, at entrances and long passages/hallways?
- Is furniture sturdy framed with four legs and no casters?
- Do tables have rounded edges defined by contrasting colours, and are they wheelchair accessible?
- Are seats upholstered in a matte, non-slip, easy to clean, fabric without bold patterns or flecking and in a colour that contrasts with the environment?
- Are chair/sofa legs able to be fitted with blocks to raise seat height?
- Does seating have a firm cushion, lumbar support, minimal back recline, and backward seat tilt?
- Are seats 460-485mm high, 457.2-508mm deep, and have clearance under the front of the seat to allow feet under the front edge?
- Are bedside tables on glides rather than wheels, and do they have easy to use levers for sliding drawers?
- Is furniture arranged to provide barrier-free access?

Elevators

- Are elevators easily located and directly accessible from main entrances and important circulation paths on each floor?
- Are elevator call buttons, both inside and outside, positioned at an accessible height, large, raised 1mm, with an appropriate colour combination and font size?
- Do elevator doors provide sufficient time when opening/closing for those with compromised mobility?
- Is there a waiting area, with appropriate seating, outside all elevator areas?