

A Summary of Senior Friendly Care in Erie St. Clair LHIN Hospitals

June 2011

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This report was developed as part of the Ontario Senior Friendly Hospital Strategy.



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1. Executive Summary

Patients over 65 years of age access all areas of healthcare with few exceptions, yet rarely do services provide care specific to the needs of seniors. It has been well documented that complications from hospitalization can have long term consequences for seniors, including loss of independence and decline in quality of life. This in turn can cost the healthcare system more to support these now frail individuals. With the aging of the baby boomers, more seniors will be accessing the healthcare system. In 2008/09 seniors 65+ accounted for 18% of the Erie St. Clair population (Bronskill, 2010). This substantial rate will continue to increase. The time has come to focus on hospital wide, Local Health Integration Network (LHIN) wide and Ontario wide strategies that support the health and recovery of senior patients.

Given that seniors receive care in virtually every area of the hospital, it is critical that continuous quality improvement plans include a comprehensive, coordinated approach to protecting and responding to the needs of a growing and increasingly diverse seniors' population.

The purpose of the LHINs' Senior Friendly Hospital Strategy is to identify Senior Friendly initiatives and support hospitals to adopt these practices. The first step is to gain an understanding of the current state of Senior Friendly care.

Each LHIN has created a summary report of Senior Friendly promising practices and areas for improvement based on self-assessments completed by organizations in their area. These summary reports provide the framework for moving the Senior Friendly Initiative forward, and will also be used to summarize initiatives across Ontario.

The Regional Geriatric Programs of Ontario's Senior Friendly Hospital Framework was used as a guideline for the hospital self-assessment templates and the subsequent summary reports. This 5 domain framework is designed to improve health and process outcomes, reduce inappropriate resource use and improve client and family satisfaction. The domains include:

- a) Organizational Support – Does the organization show its support for being a Senior Friendly Hospital in its' organizational structures and processes?
- b) 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?
- c) Emotional and Behavioural Environment – Do staff interact with older patients in a respectful, supportive and caring way?

- d) Ethics in Clinical Care and Research – Do care providers and researchers ensure that ethical issues are fully addressed with elderly patients or research subjects?
- e) Physical Environment – Is the physical environment sensitive to the capacities of elderly patients and visitors?

This summary report of the Erie St. Clair (ESC) LHIN hospital self-assessments represents a point in time snapshot of Senior Friendly hospital care in the LHIN. It identifies the strengths and areas for improvement in each of the Senior Friendly Framework domains. As well, it identifies an array of Senior Friendly practices and programs in individual ESC LHIN hospitals that could be considered for broader adoption. Within each domain, promising practices as well as potential next steps have been highlighted. These promising practices and next steps have the potential to support the Senior Friendly Initiative, but first need to be considered within the broader context of the provincial summary results as well as current best practices (practices that have been proven to be beneficial through experience and research).

The purpose of this summary is to describe the current state of Senior Friendly care as well provide potential ideas for the next step in the Senior Friendly Initiative. Recommendations and key initiatives will be provided in the upcoming Provincial Summary of Senior Friendly Care in Hospitals.

All five organizations in the ESC LHIN returned the Senior Friendly self-assessment. The ESC LHIN hospitals include: Windsor Regional Hospital, Bluewater Health, Hotel Dieu Grace Hospital, Chatham Kent Health Alliance, and Leamington District Memorial Hospital. The survey results indicated that all hospitals recognize the need for senior-specific care. All hospitals provide Senior Friendly programing in certain areas of care, but have yet to initiate a hospital-wide examination of how seniors' needs are being met. Based on the ESC LHIN Senior Friendly surveys, seniors 65+ accounted for 66% of hospital days, 86% of Alternative Level of Care (ALC) days, 20% of emergency department (ED) visits and 59% of readmissions within 30 days, averaged between 2007-2010 (non-weighted averages). ESC LHIN hospitals offer several senior specific programs, including Geriatric Emergency Management (GEM) (5/5 hospitals), Assess and Restore units (3 hospitals), psychogeriatric programs (3 hospitals) and geriatric outreach/assessment (2 hospitals). Hospitals perceived GEM programs, Acute Care and Complex Continuing Care as priorities for becoming Senior Friendly.

In the Erie St. Clair LHIN Seniors 65+ account for:

- *66% of hospital days*
- *86% of ALC days*
- *20% of ED visits*
- *59% of readmissions within 30 days*

Organizational Supports: Less than half of the ESC LHIN hospitals identified organizational supports for becoming Senior Friendly. These organizational supports included explicit Elder Care initiatives in the strategic plan, a commitment from the Board of Directors to become Senior Friendly, an identified Senior Executive lead for the Care of Elderly, and a designated committee for the Care of Elderly. Some hospitals reported future plans to initiate organizational supports like committees to explore Senior Friendly strategies. Two hospitals use specific human resource practices to hire staff with knowledge and expertise in geriatrics. Several methods for soliciting input from patients and the community were cited; however all were geared towards the general population. When organizational supports are in place, a cohesive Senior Friendly plan can be formed including policies, programs and resources.

Organizational Supports: Highlights of Current Practices

- *2 hospitals with a Senior Friendly strategy and designated senior executive lead*
- *Consideration of qualifications in geriatrics for specific roles*
- *Interview questions based on geriatric care*

Potential Next Step

- *Set a strategic plan, designate a senior executive lead, and form hospital committees for the Senior Friendly Initiative*

Process of Care: ESC LHIN hospitals support the care of seniors by implementing protocols and metrics for risk areas, using Best Practice Guidelines (BPG) and providing supportive discharge. All hospitals reported protocols and metrics for falls, restraint use and adverse drug reactions. However two or less hospitals have protocols and metrics for high risk screening, continence, hydration & nutritional status and sleep management. Two hospitals reported having BPG champions to support the care of seniors. Hospitals safely transition patients back to the community using patient care practices like self-medication programs, equipment coordination, patient education and leave of absences, as well as involving community supports like Community Care Access Centre (CCAC). High risk senior patients' needs are met in all ESC LHIN EDs through GEM programs. Health outcomes for seniors can be improved by using care practices that acknowledge the physiology, pathology and social science of aging.

Process of Care: Highlights of Current Practices

- *Use of Best Practice Guidelines, including for falls prevention, pressure ulcer prevention, pain management, and dementia*
- *Best Practice Champions on staff*
- *Partnerships with community organizations to support discharge*
- *GEM programs at all hospitals*

Potential Next Steps

- *Spread senior friendly patient practices across all hospital areas of care*
- *Adopt protocols and monitoring of all confirmed risk areas*
- *Use Best Practice Guidelines (e.g. Registered Nurses Association of Ontario BPG)*

Emotional and Behavioural Environment: All ESC LHIN hospitals provide education in geriatric care, typically to staff working in specific geriatric programs or areas of care with a high senior population. Education is provided through orientation, Lunch and Learns, education sessions and support for courses/certification. Hospitals have programs in place to promote client-centred care and cultural diversity. These programs should ensure that they meet the specific needs of senior patients as well as the general population. At this time there is little use of age sensitive satisfaction measures. Future use of these measures will allow hospitals to capture successes and areas for improvement in caring for senior patients.

Emotional and Behavioural Environment: Highlights of Current Practices

- *Ongoing staff education in geriatric care – senior specific learning sessions*
- *Client centred care: navigator boards, patient goal setting, patient conferences*
- *Use of satisfaction surveys in senior-specific programs*

Potential Next Steps

- *Provide orientation for all staff regarding seniors' needs and formal ongoing educational opportunities for staff that work with seniors*
- *Involve patients in care and discharge – e.g. goal setting, use of navigator boards, patient/family conferences*
- *Implement age-sensitive patient satisfaction measures*

Ethics in Clinical Care and Research: All hospitals in the ESC LHIN have access to an ethicist, who is most commonly involved when quality of life and end of life care practice issues arise. All hospitals also have policies on Advance Care Directives. The broad range of ethical issues around providing care to senior patients must be considered.

Ethics in Clinical Care and Research: Highlights of Current Practices

- *Access to an ethicist*
- *Policies on Advance Care Directives*

Potential Next Step

- *Ongoing ethical education and support for staff*

Physical Environment: ESC LHIN hospitals reported having a variety of physical adaptations to meet the Accessibility for Ontarians with Disabilities Act (AODA) and support the needs of seniors. Two hospitals have completed a Senior Friendly environmental audit. If Senior Friendly environmental design principles are used for capital improvement projects, the overall cumulative effect will be a barrier free and supportive environment for all patients.

Physical Environment: Highlights of Current Practices

- *Barrier free parking lot with designated parking spaces*
- *Public consultation for design of new facilities*
- *Review of physical space by the Canadian National Institute for the Blind*

Potential Next Step

- *Conduct a Senior Friendly environmental audit using peer-reviewed guidelines*

Many ESC LHIN hospitals have plans to implement general patient care initiatives that will also benefit senior patients. Some of these initiatives include “Releasing Time to Care”, Gentle Persuasive Approach education for staff, and predictive discharge. Three hospitals also plan to adopt Senior Friendly Principles through the formation of committees, use of Senior Friendly BPGs and by completing a needs assessment plan. Reported barriers to becoming Senior Friendly included lack of finances, competing priorities, aging infrastructure and difficulty recruiting geriatric specialists.

In this first step of the Senior Friendly Initiative, promising practices and areas of improvement in ESC LHIN hospitals have been identified. These include but are not limited to: identifying a Senior Executive as the lead for the care of seniors, adopting Best Practice Guidelines, providing education for all staff regarding the needs of seniors, ongoing education/ support around ethical issues and completing a Senior Friendly environmental audit. Across Ontario, LHINs and hospital organizations must work together to further develop the Senior Friendly Initiative to ensure we are meeting the needs of our large senior population.

2. The Ontario Senior Friendly Hospital Strategy in the Erie St. Clair LHIN

CONTEXT

With the growing rate of seniors, healthcare delivery and sustainability is a common question. Worldwide, seniors are concerned about accessible health care, the variety of services offered, health promotion and living options (home care, suitable residential facilities) (World Health Organization, 2007). Ontario will also see an increase in seniors accessing our health care system. We need to ensure our services meet the needs and concerns of our growing senior population.

From 2011-2031 Ontario will experience a growth in the number of seniors as baby boomers turn 65. By 2036, seniors 65+ will make up 23.4% of population, a large jump from 13.7% in 2009. Life expectancy of Ontarians is projected to increase from 83.1 years in 2006 to 87.8 years in 2036 for females and 78.8 years to 85.3 for males (Ministry of Finance, 2010). Aging itself does not directly link to increased use of health services, however as we age we are more susceptible to multiple chronic conditions. The majority (76%) of Canadian seniors reported having one or more chronic conditions, with 24% having 3 or more in 2007. Seniors with three or more chronic conditions have a higher rate of polypharmacy and health care visits than seniors with no chronic conditions (Canadian Institute for Health Information, 2001). Complications of hospitalization such as deconditioning, pressure ulcers, delirium and dehydration/malnutrition can result in a loss of independence and decline in quality of life for seniors (Bongort, 2010).

One study of an Ontario emergency department found that staff wanted to provide Senior Friendly care, but were limited by the environment, staff shortages, high complexity of cases and lack of knowledge in geriatrics. Some staff expressed moral angst when they were unable to meet seniors' needs (Kelley, 2001). Hospital organizations recognize the need for specific geriatric health services. However seniors are high users of most hospital units and services, necessitating the extension of Senior Friendly initiatives to all areas of care in the hospital (Liu, 2010). This requires a comprehensive and coherent Senior Friendly strategy that can be used throughout the ESC LHIN.

The general population in the ESC LHIN is less dense, more rural and growing slower compared to the Ontario population. Rates of arthritis, hypertension, asthma, anxiety disorders, diabetes and mood disorders are higher than the provincial rates. Seniors over the age of 65 have the highest rates for these chronic conditions (Erie St. Clair LHIN, 2009). In 2008/09 seniors (≥65 years of age) accounted for 18% of the ESC LHIN's total population (Bronskill, 2010).

The ESC LHIN's Integrated Health Service Plan 2010-2013 (2009) (IHSP2) outlines the following five strategic directions: alternative level of care, emergency department care, diabetes management (chronic disease management), mental health/ addictions and rehabilitation care/interventions. The LHIN has aligned the IHSP2 to provincial priorities, including reducing emergency department wait times, reducing ALC days and supporting the Ontario Diabetes Strategy. Senior Friendly initiatives can be used to work towards these priorities by enhancing the care of seniors in hospitals and

improving the transition from hospital to community. Implementing Senior Friendly practices in hospitals will ultimately benefit all high needs patients as well as complement other initiatives, including accreditation, clinical practice initiatives (Registered Nurses' Association of Ontario (RNAO)'s Best Practice Guidelines), capital reconstruction & accessibility plans, and Excellent Care for All (Liu, 2010).

DIRECTION OF THE SENIOR FRIENDLY HOSPITAL STRATEGY

The purpose of the LHINs' Senior Friendly Hospital strategy is to enhance the care of seniors and reduce complications that result in functional decline and loss of independence. The goal is to create Senior Friendly services across the continuum of care that promote safety, independence, autonomy and respect for our frail and often complex senior health consumers. The first step is to gain an understanding of the current state of Senior Friendly care within each LHIN. The Toronto Central (TC) LHIN has already completed a summary of promising practices, challenges and opportunities for improvement. The other remaining LHINs are now involved in this first step. The results from these summaries will provide useful feedback to each hospital and the LHIN.

The purpose of this summary is to gather information about the current state of Senior Friendly Care, highlight promising practices and identify areas for improvement. These promising practices have the potential to support Senior Friendly care, but need to be considered in a broader context. As the Senior Friendly Initiative continues, the information from the self-assessments will be used to create a provincial summary. Promising practices will be compared provincially and to current best practice guidelines (practices validated through experience and research). At this point recommendations and key strategies will be provided for the province and clusters of LHINS.

The LHINs throughout Ontario based this project on the TC LHIN's survey and subsequent summary of Senior Friendly care in their area. Initially the TC LHIN formed a task group of individuals from various hospitals and the Community Care Access Centre, with ongoing feedback from the TC LHIN Seniors Advisory Panel and Health Professionals Advisory Committee. The task group, in partnership with The Regional Geriatric Program (RGP) of Toronto, was involved in forming the following documents:

- 1) Background Document: Senior Friendly Care in TC LHIN Hospitals
- 2) The Senior Friendly Hospital self-assessment template
- 3) A Summary of Senior Friendly Care in Toronto Central LHIN Hospitals (based on completed self-assessments from all hospitals in the LHIN)

These documents have now become the basis for the Senior Friendly Initiative across Ontario. The ESC LHIN has formed a project charter for Senior Friendly Hospitals outlining the LHIN's priorities related to senior care and the steps required for this initiative. The Background Document: Senior Friendly Care in TC LHIN provides the framework to move forward. This five-domain framework has been endorsed provincially by the RGPs of Ontario and defines the key focus areas required to optimize the care of older adults in hospital. The self-assessment template was formed using the framework in order to capture successful initiatives and areas for improvement in the five domains.

3. Conceptual Underpinning – The Senior Friendly Hospital Framework

This improvement strategy requires a framework to provide a common pathway outlining organizational and system level changes. This framework must be flexible to adapt to the unique mission and culture of each hospital across the LHIN.

To help hospitals take a systematic, evidence-based approach, the Regional Geriatric Programs of Ontario developed a Senior Friendly Hospital Framework aligned with the Canadian Medical Association Principles for Medical Care of Older Persons. The framework includes five domains designed to improve health and process outcomes, reduce inappropriate resource use, and improve client and family satisfaction:

a) Organizational Support – There is leadership and support in place to make Senior Friendly care an organizational priority. When hospital leadership is committed to Senior Friendly care, it empowers the development of human resources, policies and procedures, care-giving processes, and physical spaces that are sensitive to the needs of frail patients.

b) 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. The care is delivered in a manner that ensures continuity within the health care system and with the community, so that the independence of seniors is preserved.

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

d) Ethics in Clinical Care and Research – Care provision and research is provided in a hospital environment which possesses the resources and the capacity to address unique ethical situations as they arise, thereby protecting the autonomy of patients and the interests of the most vulnerable.

e) Physical Environment – The hospital's structures, spaces, equipment, and facilities provide an environment which minimizes the vulnerabilities of frail patients to promote safety, independence, and functional well-being.

While all five components of the Senior Friendly Hospital Framework are required for optimal outcomes, it is recognized that a staged approach to change may be more feasible and practical in its implementation.

4. Goals of the Self-assessment Summary

- To serve as a summary of the current state of Senior Friendly care in the ESC LHIN
- To acknowledge promising practices in Senior Friendly care
- To identify hospital and system-level improvement opportunities
- To promote knowledge sharing of innovative practices

5. Methods

The Self-Assessment Template was created based on the TC LHIN pilot project. The Self-Assessment Template was then sent to the five hospital organizations within the ESC LHIN. All five organizations returned the completed self-assessment. Most organizations provide both acute and rehabilitation/complex continuing care (CCC) services. The one exception provides acute and psychiatric care. Total number of beds ranged from 61 to 387 (see Figure 1). Because of the small number of organizations, mixed services offered by all hospitals and limited range in number of beds, the hospitals were not grouped into comparative categories. Instead, individual self-assessment responses were compared to the ESC LHIN average where appropriate.

Each self-assessment was read and analyzed internally by a member of the LHIN, and externally by an occupational therapist and a geriatrician from the Southwestern Ontario Regional Geriatric Program (SWO RGP). As this is an exploratory project, the self-assessment was composed of mostly qualitative questions but also included quantitative items. The subjective nature of the qualitative questions required the reviewers to have some degree of familiarity with the hospital system and services. Qualitative responses were examined for common themes, and where appropriate, themes were aggregated to provide a system view. The self-assessments were examined by each reviewer independently, and consensus was reached through discussion. A draft of The Summary Report was reviewed by the ESC LHIN to provide feedback on the analysis and recommendations before the summary was finalized.

Like the self-assessment template, the summary was structured on the Senior Friendly Hospital Framework, which facilitated the identification of common areas of focus, strengths, and opportunities for improvement. In addition to the ESC LHIN summary, each hospital received an individualized feedback letter. This letter included a summary of the hospital's responses and the aggregate responses of all ESC LHIN hospitals. The feedback also highlighted the hospital's innovative Senior Friendly practices and opportunities for improvement.

Figure 1

ESC LHIN Participating Hospitals		
Organization Name	Total Number of Beds	Care Provided
Windsor Regional Hospital (WRH)	387	Acute CCC Rehab
Bluewater Health (BWH)	318	Acute CCC Rehab Psych
Hotel Dieu Grace Hospital (HDGH)	309	Acute Psych
Chatham Kent Health Alliance (CKHA)	240	Acute CCC Rehab Psych
Leamington District Memorial Hospital (LDMH)	61	Acute CCC

6. Limitations of the Analysis

Limitations arise with the open ended nature of the questions in the self-assessment template. Based on the wide and varied responses received, it was evident that different organizations interpreted some questions differently. All answers were included in the grouping of the themes which may have resulted in some themes that seem clinically unrelated to the original question. Subjective interpretation of the results by the reviewers may also be a limitation. This was mitigated as much as possible by using multiple reviewers to reach consensus.

Occasionally, organizations did not provide answers to specific questions or noted that data was not available. When this occurred the organization was removed from that specific question when calculating the results. Conversely, organizations may have underreported services and activities that, with respect to Senior Friendly care, are worthy of mention.

When calculating the data, sample size was not taken into consideration. All figures and statistics are provided using non-weighted averages.

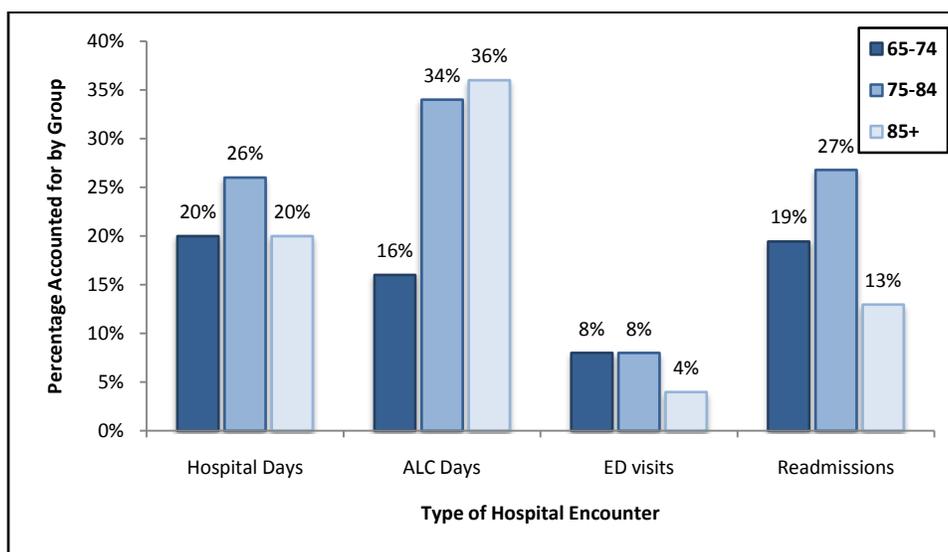
7. Findings

7.1: Priority Setting

Canadian health care spending is on the rise, with the largest growth seen in capital (e.g. construction, equipment and software), drugs and public health. Growth in costs due to population aging is estimated to be 0.95% - 1.3% per year from 2010-2030 (Constant, 2010). Contrary to popular belief that seniors will bankrupt the health care system, inflation and technological innovations will have a far greater impact on health care costs than the aging population. However the expected increase in health care spending associated with seniors still needs to be managed through changes to care delivery (Canadian Health Services Research Foundation, 2011).

Managing aging population health care costs requires examination of how seniors are using health services. Based on the ESC LHIN Senior Friendly surveys, seniors 65+ accounted for 66% of hospital days, 86% of ALC days, 20% of ED visits and 59% of readmissions within 30 days, averaged between 2007-2010 (non-weighted averages). No specific trends over the three years were noted (See Appendix 1 for data per year). Trends of use for the specific age groups of 65-74, 75-84 and 85+ can be seen in Figure 2. The middle age group accounted for an average of 26% of hospital days, a slightly larger proportion than the youngest and oldest. The middle and oldest groups account for the majority of ALC days. The middle and youngest groups were higher users of the ED compared to the oldest group. Finally the middle age group accounted for more readmissions within 30 days than the youngest and oldest groups. Overall, seniors 75-84 were a notable percentage for all types of hospital encounters. The oldest group of 85+ used the ED the least, perhaps because they are more likely to have alternative living arrangements or are waiting to be placed (accounted for a slightly higher proportion of ALC days).

Figure 2: Average Percentage of Hospital Days, ALC Days, ED Visits and Readmissions within 30 Days Accounted for by Senior Patients Grouped by Age from 2007-2010 (non weighted)



Considering seniors 65+ accounted for the majority of hospital days, ALC days and readmissions with 30 days in the ESC LHIN, the need to become Senior Friendly across hospital services is evident. Across the ESC LHIN, all hospitals reported having senior specific programs as well as several programs that are senior-focused based on the general population profile. Common senior specific programs included Geriatric Emergency Management (5/5 hospitals), Assess and Restore units (3 hospitals), psychogeriatric programs (3 hospitals) and geriatric outreach/assessment (2 hospitals). Acute care, complex continuing care and rehabilitation units were commonly cited as senior focused based on the high percentage of seniors using these services.

When asked about priorities for becoming Senior Friendly, hospitals provided a wide range of answers (Figure 3). Most of these priorities fell within the Process of Care domain in the Senior Friendly Framework, including specific programs, patient safety & quality of care, review of services and community partnerships. Additional domains addressed were Organizational Support (adoption of policies, staff education) and Physical Environment (accessibility). Emotional & Behavioural Environment and Ethics in Clinical Care & Research were not expressed explicitly in these priority areas. Further examination of each domain revealed promising practices and areas for growth within these areas.

Figure 3

Hospital Reported Senior Friendly Care Priority Areas*
Emergency Department and Inpatient Programs (4): <ul style="list-style-type: none"> • GEM • Acute Care • CCC
Patient Safety and Quality of Care (3): Including: falls prevention, elder specific screening tools, pressure ulcer prevention, UTI prevention, fractured hip program, medication, communication, dietary needs, elder abuse, dental program, self-management of chronic conditions, and the 3Ds (delirium, depression and dementia)
Adoption of Policies and Principles (3): <ul style="list-style-type: none"> • Senior Friendly Best Practice Guidelines • Excellence in Elder Care • Release Time to Care Initiative
Review of Services (2)
Staff Education and Certification (2)
Accessibility (1)
Community Partnership (1)
<i>*The number in parenthesis indicates the number of hospitals out of 5 that reported a given priority area</i>

7.2: Senior Friendly Framework Domains

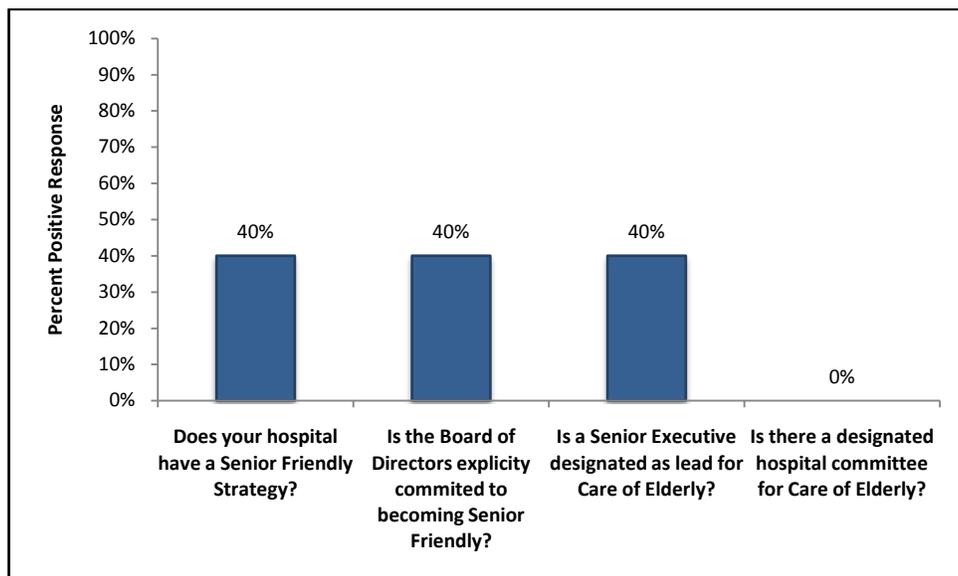
a) Organizational Support

Examples of organizational support to become Senior Friendly include explicit commitment by senior leadership, identified champions, endorsement of the Canadian Medical Association Principles for Medical Care of Older Persons, relevant policies and procedures, designated committee structures, and recruitment of staff knowledgeable in geriatrics.

At this time, less than half of the ESC LHIN hospitals identified organizational supports for becoming Senior Friendly (Figure 4). One of the hospitals that identified Senior Friendly care as a priority is specifically focused on “develop(ing) a greater expertise and focus on the needs of seniors and ‘geriatrics’ in the delivery of the acute care medical program”, including reviewing physical plan capabilities and capacity. Other hospitals are aware of the need to become Senior Friendly. One noted that while it is not in the strategic plan, the Professional Nursing Practice Team has developed a strategy/philosophy for Senior Friendly care.

The hospitals with an explicit Senior Friendly priority in the strategic plan also reported that the board of directors is committed to becoming Senior Friendly and a senior executive has been designated as the lead for the Care of Elderly. One of these hospitals also plans to form a hospital committee in the near future. The remaining organizations provide some senior specific programming and identified high numbers of senior patients in some care areas but have yet to promote Senior Friendly care through organizational supports.

Figure 4: Response to Organizational Support Questions (N = 5)



Staffing is another corner stone of providing Senior Friendly care, including recruitment, retainment and education. Hospitals within the ESC LHIN employ a varying number of staff solely dedicated to the care of seniors, from 2 to 19 full time equivalents (FTEs). Acute care, CCC and general Rehab staff were not included. Although staff in these areas may work mostly with seniors and be recognized as geriatric champions, these positions are not exclusively dedicated to senior care. Employment of GEM nurses was common to all 5 hospitals, with each hospital having 1.5-2 FTE positions. One hospital in particular noted a number of staff with specific geriatric certifications, some who are completing fellowships directly related to senior care. At this hospital over 60 staff members completed RNAO Best Practice education and are implementing Senior Friendly best practices. Another hospital noted support for staff to become certified in Gerontology and Rehabilitation.

Two hospitals reported human resource practices geared towards recruiting staff with knowledge in senior care. One hospital considers the geriatric knowledge base and skills of potential staff for positions within their geriatric services. Another hospital has implemented a pretest and interview questions related to geriatric care when hiring for CCC/Rehab, Ambulatory care and Medicine. For these programs, education in geriatrics is listed as a preferred competency.

The organizational support domain also examines the formal structures in place to solicit input from seniors, families, and partnering agencies for the development of hospital programs and services. All hospitals used some method of obtaining seniors' feedback, whether through group format or on an individual basis (Figure 5). The most common was the formation of focus groups and forums. Patients or community members also provide feedback as members of committees or councils. For example one hospital has a Patient and Family Centred Care Steering committee where half of the members are from the community, a number of them seniors. Formal processes (e.g. groups, surveys, committees) of soliciting community feedback allow for more engagement of individuals. Informal feedback methods may not reach all stakeholders, including seniors, and so should be used only in conjunction with formal processes.

All of these methods are geared toward the general population and may not encourage the participation of seniors. For example, seniors may have difficulty finding transportation to community forums, have difficulty hearing and communicating in group and individual settings, or may not be able to read surveys depending on the size of print. The needs of seniors must be taken into consideration to ensure this group is able to provide their feedback.

Figure 5

Various Methods Reported by Hospitals for Soliciting Input from Older Patients and Community*
Focus groups, Family Forums, Community Engagement Forums (3)
Patient/Community Representation on Committees/Councils (2)
Individual Feedback from Patients (2) <ul style="list-style-type: none">• Surveys• Interviews• Complaint Process
Informal Feedback from Patients and Community (2) <ul style="list-style-type: none">• Newspaper – comments• Website• Feedback during Outreach/Education days
Feedback from Community Organizations (1)
Patient Advocate (1)

*The number in parenthesis indicates the number of hospitals out of 5 that reported using a given method

Organizational supports for Senior Friendly care promote the development of a cohesive plan involving human resources, policies, care practices and physical spaces to improve the care of senior patients. Potential next steps include: committing to Senior Friendly care, designating a lead of care, forming committees and considering the needs of seniors when developing feedback methods.

Organizational Support – Local Promising Practices

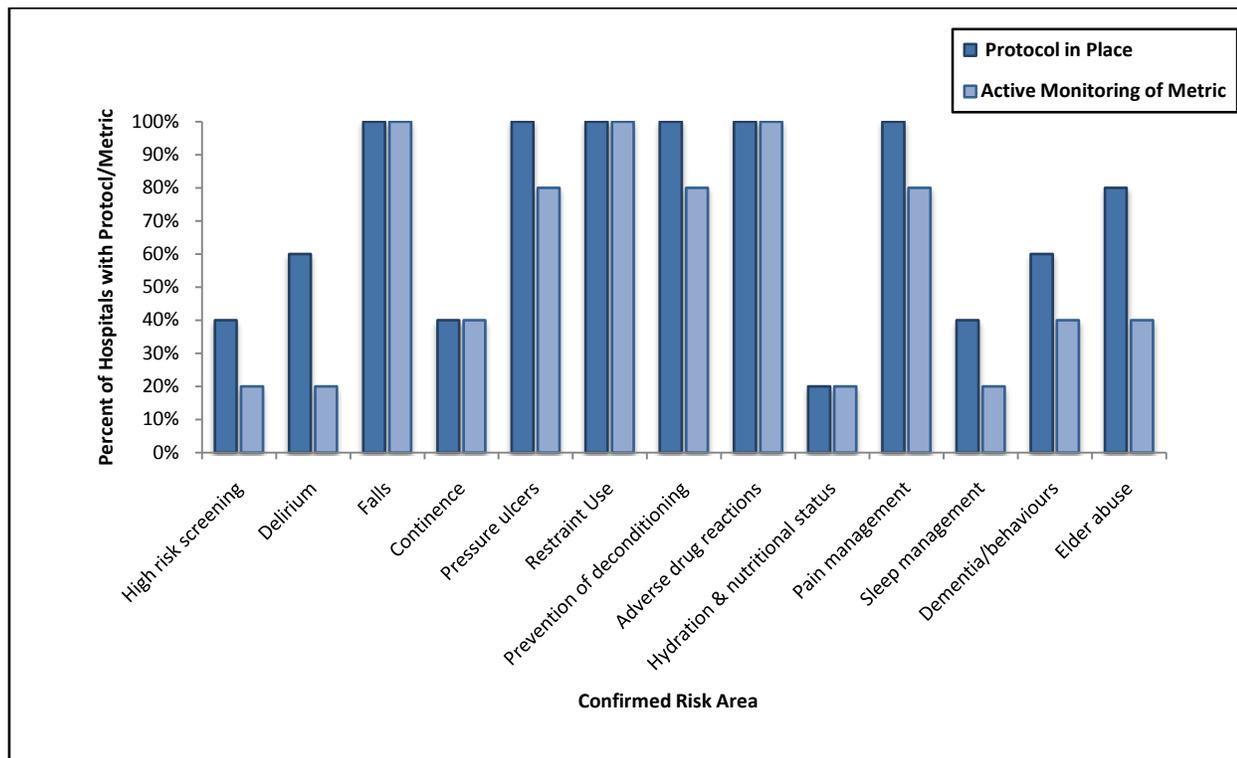
- *Commitment of senior leadership to become Senior Friendly, Steering committees to help plan and implement Senior Friendly Strategies*
- *Inclusion of knowledge and experience in geriatrics as preferred competencies for job descriptions*
- *Support for certification in Gerontology, Best Practice education and other skill development for staff who work mostly with seniors*

b) Processes of Care

The Processes of Care domain includes high risk screening for vulnerable patients, avoiding the hazards of hospitalization, using sustainable discharge practices, adoption of best practice guidelines, and implementation of geriatric programs.

It has been well documented that complications from hospitalization can have long term consequences for seniors. The ESC LHIN hospitals were asked if they use active protocols and/or monitor metrics for 13 identified clinical risk areas. All hospitals reported protocols and metrics for falls, restraint use and adverse drug reactions, and the majority reported likewise for pressure ulcers, prevention of deconditioning and pain management (Figure 6). Conversely two or less hospitals have protocols and metrics for high risk screening, continence, hydration & nutritional status, and sleep management. One hospital also has protocols and metrics in place for Wandering & Elopement and Patient Abuse.

Figure 6: Percent of Hospitals with Protocols and Active Monitoring of Confirmed Risk Areas



Several hospitals have adopted Senior Friendly Best Practice Guidelines as protocols to address these risk areas (e.g. RNAO BPGs). BPGs used by hospitals in the ESC LHIN include: fractured hip program, falls prevention, prevention of catheter associated UTIs, constipation prevention/management, pressure ulcer prevention, pain management, dementia, and strategies to support self-management in elders with chronic conditions. Two hospitals noted having BPG champions on staff to promote the use of the guidelines. Going beyond the use of best practice guidelines, one hospital reported also contributing to the baseline creation of an RNAO needs

assessment gap analysis for Pain Management in Long Term Care (LTC). The implementation of best practice guidelines ensures that patients receive evidence-based quality care that supports seniors' needs.

In a study of geriatric 'quality indicators' for hospital care there was a significantly higher rate of compliance with quality indicators for general medical care (e.g., pain, venous thromboembolism, nutrition and discharge planning) versus geriatric-specific care indicators (e.g. delirium, dementia, pressure ulcers and physical function) (Arora, 2007). While some of these geriatric-specific care indicators are used by hospitals in the ESC LHIN, other indicators such as high risk screening, dementia, and delirium are addressed by 3 or less hospitals. It should also be noted that some care areas have provincially mandated indicators. For example, CCC units must report metrics on falls, continence, pressure ulcers, restraint use, pain and responsive behaviours. Not surprisingly, these were generally the risk areas with a higher reported use of metrics than areas like high risk screening, delirium, hydration & nutritional status, sleep management and elder abuse.

At this time hospitals are using a wide variety of metrics to monitor these risk areas, making it difficult to summarize across the LHIN or the province (Appendix 2). For example, some hospitals collect the rate of all falls, while others only include falls with injury. Some metrics end up skewing data when used comparatively across the LHIN e.g. a large percentage of patients with pressure ulcers could translate into 1 or 2 patients in a small hospital. The difference between a protocol and a metric will have to be clarified for further Senior Friendly self-assessments. Hospitals reported individual patient assessments as protocols (e.g. Morse Falls Scale for falls) for some risk areas, but as metrics in other areas (e.g. cognitive assessments for high risk screening). In order to capture an accurate picture of senior care across the LHIN, metrics for risk areas must be consistent across hospitals, stratified for age, used in all care areas where there are senior patients, and easily aggregated.

Supportive transitions and discharge planning are key features of Senior Friendly hospital care. All hospitals reported using patient care practices within the hospital to support discharge (Figure 7). Some unique practices included sending the patient home with the dosette that they learned how to use in the hospital, and educating patients using the RAO Best Practice Health Education fact sheets. There was also a strong focus on community partnerships. Two hospitals noted the benefit of having CCAC staff directly on the unit, and another reported having Placement Co-ordination Services based within the hospital. Several hospitals have close ties to community programs like CCAC Extenuating Circumstances program or the Resettlement program. Programs within the hospital can also support successful discharge, like the new Assess and Restore Units designed to provide rehabilitation to seniors. One Assess and Restore unit has set targeted minimal standards for Activities of Daily Living for patients to ensure a smooth transition home, and another has PSW support that transitions with the patient from the hospital to the home, short term. Using predictive discharge tools was an underreported area that could be a promising practice when planning for smooth discharge.

Figure 7

Discharge Planning Practices to Support Safe and Sustainable Discharges for Senior Patients*	
Patient Care Practices (5)	<ul style="list-style-type: none"> • Self-Medication program • Equipment coordination • Leave of Absences and graduated discharge • Provide education
Community Supports (4)	<ul style="list-style-type: none"> • CCAC – supports and follow up after discharge • Alternate agency referrals
Staff Communication (4)	<ul style="list-style-type: none"> • Bullet rounds • Interdisciplinary rounds/patient care conferences including community agencies
Staffing (4)	<ul style="list-style-type: none"> • Full time CCAC staff on unit • Social work for discharge planning • Patient flow coordinators
Hospital Programs (3)	<ul style="list-style-type: none"> • Assess and Restore Unit • ALC pilot unit in Acute Care – cohort patients waiting for LTC
Advanced Planning (2)	<ul style="list-style-type: none"> • Predictive discharge • Blaylock scale
Patient/Family Communication (1)	<ul style="list-style-type: none"> • Communication board with “Red Light/Green Light” • Family meetings
*The number in parenthesis indicates the number of hospitals out of 5 that reported using a given practice	

While the overall rate of ED visits in the ESC LHIN remained relatively stable from 2004-05 to 2008-09, there was a slight increase (2.3%) in the number of visits by seniors 65+ (measured by ED visits/1000 people). This small increase can translate to greater costs, considering an ED visit by a senior costs more than for the general population (\$400 compared to \$258 in the ESC LHIN in 2007-08) (Canadian Institute for Health information, 2010). One study found that providing Senior Friendly care proved difficult in the fast-paced, overcrowded, chaotic environment of the ED and often expectations of seniors were not met (Kelley, 2001). All ESC hospitals described the success of Geriatric Emergency Management programs in providing Senior Friendly care, avoiding admittance and avoiding repeat ED visits. Reported benefits of GEM nurses included providing coordinated care & discharge planning for high risk seniors, as well as educating other ED staff about the care of elderly patients. One hospital described a partnership with nursing/retirement homes where GEM nurses complete assessments and follow ups within the community. Other promising ED practices included having CCAC staff within the ED, ED based utilization nurses, clinical decisions units and use of the Ontario Telemedicine Program.

The ESC LHIN hospitals reported a wide variety of successful Senior Friendly initiatives, from specific patient safety protocols to programs geared towards seniors (Figure 8). See Section 9 “Highlights of Innovations Across the ESC LHIN” for further explanation of successful initiatives. To improve Senior Friendly care in hospitals, appropriate practices and protocols should become hospital wide rather than specific to units with a high population of seniors.

Figure 8

Highlights of Successful Senior Friendly Initiatives Across LHIN
Falls Prevention: Morse Fall Risk Assessment, assessed on admission and with condition changes, across all programs
Pressure Ulcer Prevention: use of Braden scale in ED and all inpatient units, completed daily
Medication: medication reconciliation (65+ flagged), self-medication program
Pain Management: use of best practice guideline scales
Ambulation assessment
Wandering and Elopement Policy and Procedure (Medical/Surgical units)
Least Restraint Program: in all inpatient areas
FLO Collaborative: bullet rounds
Emergency Department: GEM nurses, Blaylock Tool for discharge planning
Hospitalist Program: comprehensive acute care to elderly patients
Assess and Restore Unit for seniors: goals oriented charting to support ADLs
Geriatric Mental Health Outreach Program
Stroke Strategy: across all dimensions of care

To promote the health of seniors and avoid the hazards of hospitalization, care practices that consider the physiology, pathology and social science of aging must be used. Potential next steps include: adoption of best practices for all confirmed risk areas, forming standards for reporting metrics of confirmed risk areas to support comparison across the LHIN and province, and spreading Senior Friendly care practices to all hospital areas of care.

Processes of Care – Local Promising Practices

- *Use of Best Practice Guidelines for some confirmed risk areas for seniors*
- *Assess and Restore units for seniors – programs and practices designed to support rehabilitation*
- *Supportive Discharge Practices - predictive discharge tools and collaboration with community partners to ensure proper supports and follow up*

c) Emotional and Behavioural Environment

The Emotional and Behavioural Environment domain includes respect and courtesy of staff, patient centred care and cultural sensitivity. A senior's experience in the hospital typically involves contact with clinical and non-clinical staff at various levels of the organization. Education of all hospital staff helps to foster a Senior Friendly emotional and behavioural environment. All ESC hospitals support continuing education in geriatrics. Most of this education is geared toward staff working in geriatric programs or programs with a high number of elderly patients. Examples included Gentle Persuasive Approaches, The 3Ds (delirium, depression and dementia) workshops for surgical & rehab staff, GEM nurses educating acute care/ED staff and physician grand rounds. One hospital has a yearly mandatory educational module on Skin Fragility of the Elder.

Some hospitals implement hospital wide senior education, including Lunch and Learns for all staff and corporate education supported by professional practice nurses. One hospital includes patient and family centred care, service excellence and Accessibility for Ontarians with Disabilities Act training in orientation for all staff and students. Issues related to senior patients are addressed within this orientation. Another hospital is now planning senior specific learning sessions (elder abuse and screening, ageism, depression), and may incorporate Senior Friendly training into staff orientation. Basic geriatric education for all staff would be useful, considering that seniors account for a large proportion of patients in most areas of the hospital.

All hospitals reported having programs in place that promote client-centred care and cultural diversity. Programs and initiatives, like navigator boards, family/patient conferences (including at orientation) and patient involvement in goal setting, help to involve and inform patients in their own care and decision making. All hospitals have translator services available, either through Language Line or through volunteers. One hospital reported using Canadian Hearing Society services. Cultural services mentioned included spiritual counseling, partnership with a First Nations group and a designated French Language Services area. While all these services and programs are useful in supporting client-centred care and cultural diversity, special considerations may be required for seniors (how to access, vision and hearing needs, sensitivity training for volunteers etc.).

At this time there is little use of age sensitive satisfaction measures to examine the patient experience specific to seniors. Hospitals reported using NRC Picker to measure patient satisfaction, but results are currently not filtered for age. One Assess and Restore Unit is using age sensitive satisfaction measures developed in consultation with a research expert. Using age sensitive satisfaction measures would allow hospitals to capture the successes and areas for improvement in the Senior Friendly strategies and programs they provide.

By delivering care that respects the unique needs of seniors, hospitals can improve the quality of and satisfaction with the hospital experience. Potential next steps include: orientation for all staff regarding seniors' needs, formal ongoing educational opportunities for staff that work with seniors, consideration of seniors' needs in client centred and cultural diversity initiatives, and implementation of age sensitive satisfaction measures to assess Senior Friendly initiatives and programs.

Emotional and Behavioural Environment – Local Promising Practices

- *General education and sensitivity training pertaining to seniors for all staff and students, specific ongoing education for staff who work directly with senior patients*
- *Use of age sensitive satisfaction measures in a senior-specific program*

d) Ethical Issues in Clinical Care and Research

Ethical concerns, including competency and end-of-life issues, often arise when providing care to senior patients. Senior Friendly hospitals address the following ethical concerns: treatment options, privacy & confidentiality, autonomy & decision making of patients, competency & capacity, dispute resolution, and advance directives.

All hospitals across the ESC LHIN reported having access to an ethicist who provides advice and consultations for complex ethical issues as they emerge. Hospitals most commonly involve an ethicist when dealing with patient care practices around quality of life and end of life care (Figure 9).

All hospitals also have policies on Advance Care Directives. The last time policies were updated ranged from 2002 to currently being redeveloped. One hospital noted using the specific mental health advanced directive “Ulysses contract” within their mental health program.

Hospitals described a similar process when issues arise concerning patient competency and capacity. After cognitive/neurological assessments are completed, either the team or individual staff members (typically Social Work or Medicine Patient Navigators with Physicians) discuss the issue of capacity. An outside capacity assessor is involved when deemed necessary.

Figure 9

Common Ethical Issues Requiring the Involvement of an Ethicist*
Quality of Life and End of Life Care Practices (5) <ul style="list-style-type: none">• Artificial nutrition• First bed policy• Accommodation – cohorting for flow, cohabitation of long term partners• Do Not Resuscitate orders
Patient/Family Decision Making (3) <ul style="list-style-type: none">• Right to refuse treatment, choice to live at risk• Substitute decision makers and family conflict• Power of Attorney• Capacity
Consent and Confidentiality (2)
Staff Decision Making (1) <ul style="list-style-type: none">• Implications of legislation for staff• Perceived conflict between principles and policy• Ethical use of resources
Access and right to care (ageism) (1)
<i>*The number in parenthesis indicates the number of hospitals out of 5 that reported a given ethical issue</i>

ESC LHIN hospitals possess the resources and appropriate structures to respond to ethical challenges. Potential next steps include: ongoing ethical education and support to ensure that staff are able to access resources and manage unique ethical situations as they arise.

Ethics in Clinical Care and Research –Local Promising Practices

- *Consideration of the broad range of ethical issues when providing care to senior patients*

e) Physical Environment

Aspects of the physical environment include way finding, visual features, physical space, sensory comfort and furniture. Seniors may require environmental adaptations beyond the Accessibility for Ontarians with Disabilities Act because of specific age related changes. Vision changes in seniors can result in sensitivity to glare, decreased field of vision, reduced sensitivity to contrast, decreased low light vision and reduced ability to see blue-green colours. Seniors may experience overall reduced hearing as well as increased sensitivity to high frequency noises, difficulty locating the source of sound and reduced ability to filter background noise. Overall deconditioning or specific physical limitations may make mobilization more difficult and increase the risk for falls for seniors. Some environmental changes to hospitals can be implemented at no to low cost, while other adaptations may be at a significant cost (Bongort, 2010).

At this time 2 hospitals in the ESC LHIN have completed a Senior Friendly Environmental audit. Two hospitals reported future plans to examine the physical space of the hospital in terms of accessibility, disability and age sensitivity. Hospitals reported having a variety of physical adaptations to meet AODA regulations and support the needs of seniors. The most commonly completed environmental changes included hallways/doors, parking/accessibility and furniture. Hospitals stated hallways are typically 6 feet wide, and some doors have wider openings to accommodate beds and equipment. Some parking lots meet building codes and site plan control, while other hospitals have gone beyond basic requirements. One hospital noted a barrier free lot with designated dialysis/oncology and accessible parking spaces as well as a drop off at the front. A number of hospitals have purchased new furniture, including items like Hi-Lo beds for falls risk patients and high back chairs. Out of all the physical features outlined in the survey, at least 2 out of the 5 hospitals had addressed each item.

Several hospitals reported using accessibility features beyond AODA regulations including: Senior Friendly signage/wayfinding, front door drop off, wheelchairs at entrances, elevator access to underground parking, shuttle service for seniors through a community organization, and volunteers to assist with parking machines, wayfinding and calling for transportation.

Capital improvement projects and significant infrastructure renewals are ongoing, long-term undertakings. If Senior Friendly environmental design principles are used for each project, the overall cumulative effect will be a barrier free and supportive environment for all patients. This requires that staff involved in capital development and physical infrastructure have training and access to resources regarding Senior Friendly/barrier free environmental design. Organizations should also consider more comprehensive training and education in Senior Friendly environmental design for staff involved in the development, maintenance, and purchasing operations of the physical plant.

To create physical spaces that promote the safety, independence and functional well-being of seniors, hospitals must examine current spaces and plan for future spaces that accommodate seniors' specific needs. Potential next steps include: completion of Senior Friendly environmental audits, use of Senior Friendly design principles in future capital planning and training for staff involved in physical maintenance/planning.

Physical Environment –Local Promising Practices

- *Completion of an evidence-based Senior Friendly environmental audit of current physical space*
- *Consideration of features beyond AODA regulations: signage, front door drop off, and use of volunteers*

8. Highlights of Innovations Across the Erie St. Clair LHIN

ORGANIZATIONAL SUPPORT

Staff Education

- **Orientation:** includes Patient/Family Centred Care, Service Excellence and AODA training (CKHA)
- **Continuing education for staff:** yearly mandatory module on Skin Fragility of the Elder, Fundamentals of Palliative Care, Comprehensive Advanced Palliative Care Education, Palliative and End of Life Care, The 3Ds workshop, Putting the P.I.E.C.E.S. Together (LDMH); Gentle Persuasion, Excellence in Elder Care (CKHA)
- **RNAO Best Practice Champions:** more than 60 staff have completed education, 5 staff have completed Fellowships (CKHA)
- **Hospital wide Lunch and Learns:** includes topics like Dementia, Alzheimer's, GEM nurse role, Stroke care (BWH)
- **Physician Grand Rounds:** includes topics like frailty, rehabilitation, fractured hips, & geriatric care (CKHA)

Human Resource Practices

- **Job descriptions:** Formal education in Geriatrics a preferred competency for Medicine and CCC/Rehab staff (CKHA), considers geriatric skills requirements for potential staff in geriatric services (WRH)
- **Interviews:** pretest and questions related to care of elderly for potential staff in CCC/Rehab, Ambulatory Care and Medicine programs (CKHA)

PROCESSES OF CARE

Specialized Units and Programs

- **Assess and Restore Unit:** rehabilitation program for 65+ to improve functioning and facilitate a safe discharge home, sets minimal goals for Activities of Daily Living for discharge (HDGH)
- **Geriatric Support Services:** Geriatric Assessment Program, DriveABLE, Adult Day Program (WRH)

Clinical Care Protocols and Pathways

- **"Release Time to Care" initiative:** goal is to increase the amount of direct patient care by improving the organization and processes on units (BWH)
- **Total Joint Replacement Care Path:** four hours of pre-operation education (including in patients' home, physiotherapy department and preadmission clinic). All patients assessed preoperatively for potential of delirium (CKHA)
- **Morse Fall Risk Assessment:** examines risk factors including medical status, falls history, mobility and cognition. Can be used at admission, with change in condition, at transfer to another unit and after a fall (WRH, HDGH)

Communication and participation of patient and family

- **Orientation family conferences:** patient and family establish goals with team (BWH)
- **Goal setting:** patients prioritize meaningful activities required to be safely discharged (LDMH)
- **Navigation boards:** daily updates of care team, appointments, questions from family (CKHA, HDGD, LDMH)

Patient Goals - Functioning and Mobility

- **Self-medication program:** patients manage meds under supervision of staff. Education is provided, and a dosette is sent home at discharge. On Assess and Restore and CCC units (LDMH)
- **Activation program:** improves functional abilities of seniors to promote safe discharge home. Currently on CCC and Acute Medicine units (CKHA)
- **Ambulation Assistant Program:** improves mobility and reduces deconditioning (WRH, HDGH)
- **“Exercises at the Kitchen Sink Program”:** DVD by physiotherapy for community use (CKHA)
- **Wanderguard system:** arm or ankle band so patients who wander are able to walk freely around unit, alarm sounds if they leave unit (CKHA)
- **Patient education:** provides RNAO Best Practice Health Education Fact sheets (LDMH)

Discharge Practices

- **Blaylock Assessment tool:** used at or shortly after admission to identify discharge planning needs (BWH, CKHA, WRH)
- **Graduated discharge:** PSW transitions home with patient from Assess and Restore Unit, short term (LDMH)

ED Practices

- **Technology:** Ontario Telemedicine Program (videoconferencing) for assessments in ED (CKHA)
- **GEM program:** includes assessments and follow up at partnering LTC homes (CKHA)

Partnerships

- **Case Managers:** CCAC and Placement Coordination Services Case Managers in hospital (BWH)
- **CCAC Extenuating Circumstances program:** hospital partners with CCAC for difficult placements (level of care required or behavioural issues) (CKHA)
- **Shuttle service:** through Lambton Elderly Outreach (BWH)
- **Bkejwanong First Nations:** hospital partners with group to support patients (CKHA)
- **French Language Services area:** to support French speaking patients (CKHA)

EMOTIONAL AND BEHAVIOURAL ENVIRONMENT

- **Patient and Family Centred Care Steering committee:** 50% are community members, many seniors (CKHA)
- **Patient Advisor:** on all program/quality councils (CKHA)

PHYSICAL ENVIRONMENT

- **Construction of new facilities:** included public consultation in planning accessible and safe features for all populations (e.g. barrier free parking lot) (BWH)
- **Imagine project:** future physical space planning including accessibility, disability and age sensitive issues (CKHA)

9. Looking Ahead – Moving toward Senior Friendly Hospital Care in the Erie St. Clair LHIN

Erie St. Clair LHIN hospitals have noted a number of promising practices within the five domains of the Senior Friendly Hospital Framework. Because becoming Senior Friendly is a relatively new initiative, each hospital has areas for improvement as well. While there are examples of excellent senior-specific programming within the area, hospitals have yet to adopt a hospital wide Senior Friendly initiative through explicit strategic planning.

All hospitals recognized the unique needs of and considerations for senior patients. Some hospitals highlighted excellent geriatric champions within their staff who promote Senior Friendly care. However strategies, programming and monitoring of risk areas are typically only in units or programs where there is a high senior population. By extending some of these initiatives throughout the hospital, we can meet the needs of seniors as well as other high risk populations.

All organizations have measures in place to ensure care is patient-centred, safe, and ethical. Often, these initiatives are geared to the general population and could be improved upon by considering the needs of the high numbers of seniors in hospitals. To measure the quality of care provided, Senior Friendly indicators and patient satisfaction measures will be required. This should be done with consideration for reporting requirements for overarching quality agendas (Excellent Care for All Act, the Canadian Patient Safety Institute and accreditation processes).

Many hospitals reported current or future plans for updating the physical environment, whether one unit or a whole site. Hospitals can move towards a Senior Friendly environment over time by ensuring that regular procurement and design decisions are made considering the needs of seniors. This leads to a hospital environment that not only accommodates the needs of seniors, but is also friendly for people of all ages and disability levels.

Many hospitals noted benefits of completing the Senior Friendly Hospital Survey, including recognizing the need to apply Senior Friendly strategies across hospital programs and in physical planning, to support the education of clinical leaders, and to develop age sensitive metrics. The most common goal or plan for the future was to implement general patient care initiatives that will also benefit senior patients (Figure 10). Several hospitals were also interested in exploring Senior Friendly Strategies further.

Figure 10

Hospital Reported Goals and Plans to Enhance Senior Friendly Care	
General Patient Care Initiatives	<ul style="list-style-type: none">• 'Releasing Time to Care' initiative• Gentle Persuasive Approaches• Predictive discharge• Utilization Management tool• Coordinate services for 7 days per week• Develop ALC unit• Increase CCC/Rehab beds
Adopt Senior Friendly Principles	<ul style="list-style-type: none">• Staff teams and study groups• Continue with Senior Friendly BPG• Needs Assessment Plan
Staff	<ul style="list-style-type: none">• Orientation, education, CNA certification• Identify Clinical leaders• Implement FLO coordinator positions
Senior Specific Patient Care Initiatives	<ul style="list-style-type: none">• Evaluate GEM program• Risk assessment of all seniors

When asked about barriers to becoming Senior Friendly, four of the five hospitals mentioned lack of finances, including funds for education and the reimbursement model for geriatricians. Competing priorities as well as aging infrastructure were also mentioned frequently. One hospital reported difficulty in recruiting geriatric specialists. Another felt staff perceptions of their role can sometimes limit Senior Friendly care. Finally, ageism in society and in health care providers can be a limitation.

Hospitals felt that the LHIN has a role in promoting a system wide approach to Senior Friendly care. Suggestions included supporting a system wide program to address risk prevention, aligning measures and processes for reporting metrics, supporting a systems needs assessment, providing funding for nurse practitioners and initiating a LHIN program with a director for Senior Care. Hospitals provided age-specific indicators they currently use, as well as suggested potential indicators related to seniors' care for the Hospital Service Accountability Agreements (Figure 11).

Figure 11

Age-Specific Indicators of Utilization and Quality of Care
Admissions Rates <ul style="list-style-type: none">• Patient days by age• Readmissions• ED visits
Demographics of ED, Inpatient, and Mental Health patients
Patient Safety Indicators <ul style="list-style-type: none">• Falls, Hospital Acquired Infections, Urinary Tract Infections (UTIs), Pneumonia, Pressure Ulcers• Software stratifies by age (e.g. Chronic Care Reporting System, National Rehabilitation Reporting System)
Specific Inpatient Units <ul style="list-style-type: none">• Assess and Restore Unit utilization by age• Activation program – % patients admitted from home discharged home
GEM indicators <ul style="list-style-type: none">• # screened (using Triage Risk Screening Tool)• # assessed (including: total, on weekends, patients without family physician/primary care provider, from LTC home, from rest/retirement residence, patients with CCAC supports, patients with falls history)• # of ED GEM referrals who left without receiving treatment• Wait times for GEM patients from triage to ED discharge• # admitted to inpatient unit• # of admission avoidance• # referred to CCAC• Repeat visit rates, # of repeat visits from seniors seen by GEM in last 7 days and in last 30 days
Potential Indicators for Hospital Service Accountability Agreements
Align with Quality of Care and Excellent Care for All Indicators <ul style="list-style-type: none">• Falls, Poly-pharmacy, Wandering/Elopement, UTIs, Pressure Ulcers, Pneumonia, Deconditioning
Admission and Discharge Rates <ul style="list-style-type: none">• Admission avoidance rates because of GEM and CCAC in ED• Readmission rates for ages 70+• Rate of patients aged 70+ from home discharged back home• Rate of Assess and Restore program patients discharged to home/community
Physical Environment Indicators <ul style="list-style-type: none">• Require Senior Friendly principles for upgrades/ new facilities project funding• 2-3 physical indicators
Report process and balancing indicators by age group including seniors

The Ontario Senior Friendly Hospital Strategy is designed to inform hospitals' senior leaders about how to modify the organization and provision of care to older patients. Additionally, it is intended to emphasize the multiple dimensions of organizational change that are needed to improve health outcomes for seniors.

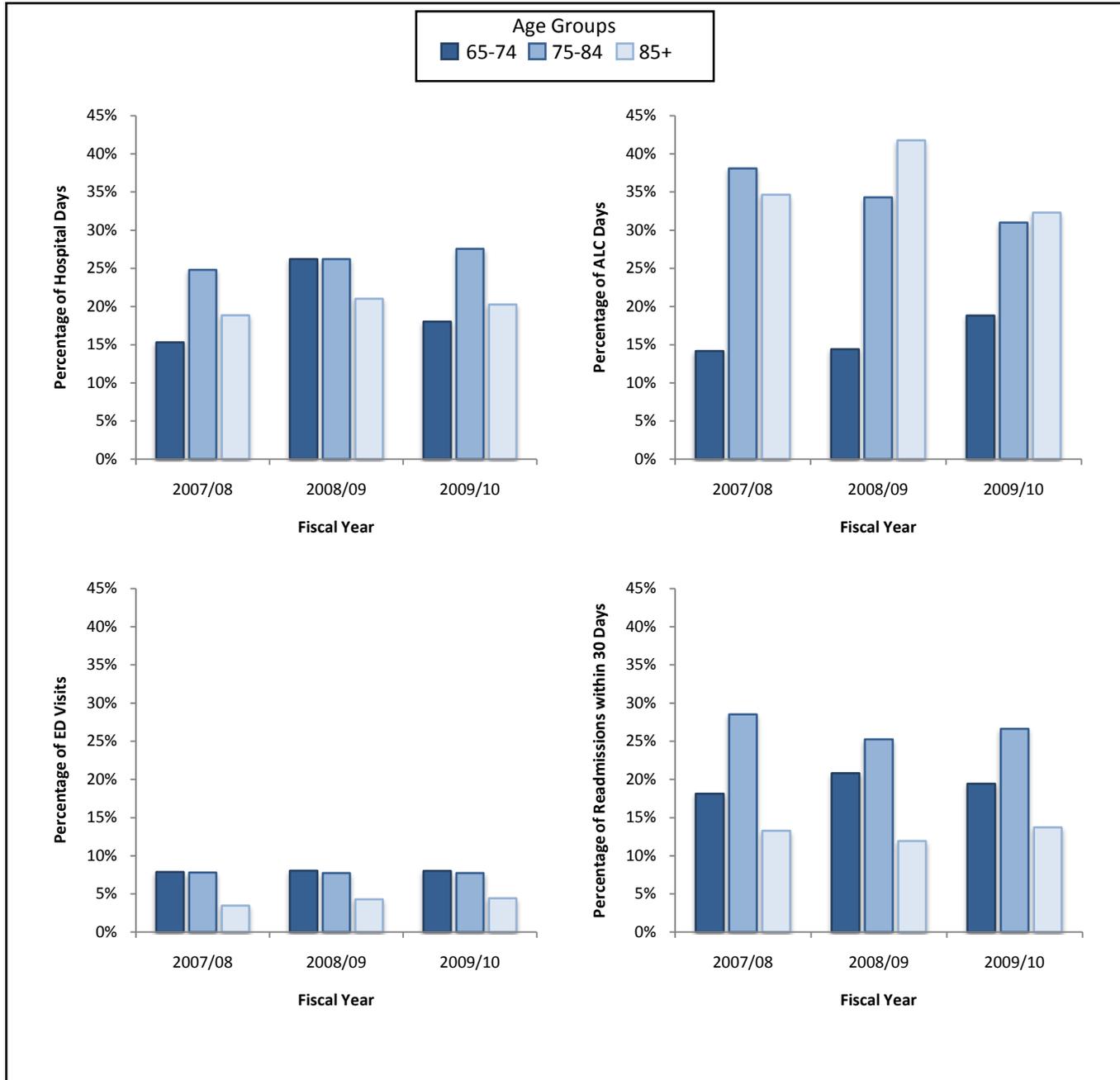
In this first step of determining the state of Senior Friendly care in the ESC LHIN, the Senior Friendly Hospital Framework was used to examine promising practices and areas for growth within this area. Many ESC LHIN hospitals currently have Senior Friendly programs and initiatives, and some have set future plans.

In the next steps of the provincial strategy, an Ontario-wide survey of leading practices, tied to best evidence on Senior Friendly hospital care, will guide the province and the LHINs in identifying specific areas of focus for improvement. The provincial report will also guide a task group assigned with the development of indicators to track improvements in Senior Friendly hospital care within the LHINs and across the province. The ESC LHIN will support its hospital organizations in adopting the Senior Friendly Hospital Framework and integrating measurable objectives into hospital service accountability agreements. This evolving work also provides concrete opportunities for hospitals to achieve their commitments within other overarching quality programs, and it will be important to consider alignment with indicators related to the Excellent Care for All Act, the Canadian Patient Safety Institute (CPSI), and accreditation processes.

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Appendix 1: ESC LHIN Percentage of Hospital Days, ALC Days, ED Visits and Readmissions within 30 Days Accounted for by Senior Patients Grouped by Age from 2007-2010*



* Based on data provided in the Self-Assessment Survey

Appendix 2: Types of Reported Protocols and Metrics Used for Confirmed Risk Areas*

Confirmed Risk Area	Reported Protocol	Reported Metric
High Risk Screening	Pharmacy Screening (1), In preadmit clinic/ ED/ discharge planning (1)	Delirium Risks, Triage Risk assessments, Cognitive assessments, and Blaylock Scale (1)
Delirium	3Ds screening (1), Geriatric Assessment Program (1), Assessed in preadmit clinic for joint replacement surgeries (1)	Code (1), Chronic Care Reporting System (CCRS) (1)
Falls	Morse Fall Scale (2), RNAO BPG (1), Falls Prevention Safety Bundle (1)	Incident Reporting Improves Safety System (IRISS)(1), United System Management System (USMS) (1), Falls with injury/1000 Patient Days (1), Falls/1000 days (1)
Continenence	GEM continence assessment, RNAO BPG and LHIN GEM protocols (1)	CCRS (1), ad hoc chart audits (1), Health Outcomes for Better Information and Care (HOBIC) indicators (1), Catheter days (1), UTI rates (1)
Pressure Ulcers	RNAO BPG (including Braden Scale) (2), Pressure Ulcer Prevention Safety Bundle (1)	CCRS (1), code (1), Braden scale compliance/ Intervention compliance (1), Monitor assessment/implementation and reassessment of patient pain (1)
Restraint Use	Least Restraint (1)	CCRS (2), Restraint use per day (1), Monthly audits (1)
Prevention of Deconditioning/ Loss of Function	Ambulation Assistant Program (2), Activation Program (1)	CCRS (2), Number of walkers per day (1), % of patients 70+ discharged home (1)
Adverse Drug Reactions/Medication Errors	Policy (1), Pharmacy Consult generated through Safety Reporting System (1)	IRISS(1), CCRS (1), Total medication incidents (1), Risk Pro (1), Safe Medication Team monitors adverse events (1)
Maintaining Hydration and Nutritional Status	On Assess and Restore Unit (1)	CCRS (1)
Pain Management	RNAO BPG (1), documentation tool in the surgical program (1)	CCRS (2), audit (1)
Sleep Management	3Ds (1), Assessment by GEM (1)	CCRS (1)
Dementia/Behavioural Disturbances	-RNAO BPG and ED assessment protocol (1)	CCRS (2), Code (1), LHIN GEM program indicators (1)
Elder Abuse	GEM screening (1), Patient Abuse Policy and Procedure (1)	RiskPro (1)

**The number in parenthesis indicates the number of hospitals out of 4 that reported a specific protocol or metric. One hospital did not provide any qualitative answers.*

Appendix 3: Self-Assessment Aggregate Responses

Self-Assessment Question	Aggregate All Hospital Response (N = 5)
A1. Does your hospital have a Senior Friendly strategy?	40% Yes
C1.1. Has the Board of Directors made an explicit commitment to become a Senior Friendly Hospital?	40% Yes
C1.2. Has a senior executive been designated as the organizational lead for Geriatric/Care of the Elderly initiatives?	40% Yes
C1.4. Do you have a designated hospital committee for Care of the Elderly? (does not include committees for a specific Senior Friendly initiative)	0% Yes
C2.1. These are areas of confirmed risk for seniors. Does your organization have protocols and metrics to address the following issues?	65% of protocols and metrics are in place for confirmed senior risk areas
C3.1 Do your staff orientation and education programs have defined learning objectives for senior care?	40% Yes
C3.2. Are age-sensitive patient satisfaction measures incorporated into hospital quality management strategies?	0% Yes
C3.3. Do you have programs and processes in place to help older patients feel informed and involved about decisions affecting their care?	20%, Yes*
C3.4. Do you have programs and processes in place to support cultural diversity among seniors and their families?	0% Yes*
C3.5. Do you have programs and processes in place to support appropriate attitudes and behaviours of health professional students and residents toward older patients?	20% Yes*
C4.1. Does your staff have access to an ethicist to advise on ethical issues related to care of older patients?	100% Yes
C4.2 Does your hospital have a specific policy on Advance Care Directives?	100% Yes
C5.2. Has your hospital conducted any Senior Friendly environmental audits of physical space using peer-reviewed guidelines (e.g. RGP audit, CodePlus or other)?	40% Yes

* Only senior specific programs were counted