Senior Friendly Hospital Care in the South West
Local Health Integration Network
Summary of Self-Assessment Responses

February 2015
In 2011, the Ontario Senior Friendly Hospital (SFH) Strategy was launched by Ontario’s Local Health Integration Networks (LHINs) and Regional Geriatric Programs (RGP)s. An environmental scan, informed by 155 hospital self-assessment surveys, highlighted promising practices within the five domains of the Ontario SFH framework: Organizational Support; Processes of Care; Emotional and Behavioural Environment; Ethics in Clinical Care and Research; and Physical Environment. The “Senior Friendly Hospital Care Across Ontario Summary Report 2011” identified delirium, functional decline, and transitions in care as priority areas for quality improvement across the province.

The current report summarizes an environmental scan conducted in the fall of 2014 using an updated version of the original self-assessment survey. The purpose of this report is to identify improvements made in SFH commitment and care since 2011; facilitate organization- and LHIN-level planning of SFH activities; highlight new and existing promising practices; and identify training needs to build capacity. Sixteen South West LHIN hospitals or hospital sites participated in the environmental scan. In some cases, separate sites of a multi-site organization completed their own self-assessments. Submissions were received from: Alexandra Hospital – Ingersoll, Alexandra Marine and General Hospital, Four Counties Health Services, Grey Bruce Health Services, Hanover and District Hospital, Huron Perth Healthcare Alliance, Listowel Memorial Hospital, London Health Sciences Centre, South Bruce Grey Health Centre – Walkerton Site, South Huron Hospital Association, St. Joseph’s Health Centre, St. Thomas Elgin General Hospital, Strathroy Middlesex General Hospital, Tillsonburg District Memorial Hospital, Wingham and District Hospital, and Woodstock Hospital.

While self-assessment can provide helpful and practical information, this approach does come with some limitations. For instance, detail and accuracy can be compromised due to different interpretations of the survey questions and inter-departmental communication. Even with explanatory notes, positive responses to dichotomous questions may lack sufficient detail about important factors such as intensity of uptake and fidelity to best practice. In the “Process of Care” domain, for example, hospitals reported the extent of implementation of practice across their organization, but not their compliance with these practices. Because several hospitals commented that compliance rates remain a significant area for improvement, the reported degree of implementation does not reflect robust adoption of practice. It is important to consider these limitations when reviewing the results in this summary.

Each section of this report summarizes responses within a domain of the SFH framework. A summary table lists the percentage of hospitals that have adopted key practices either across their entire organization or on specific units. The “Processes of Care” section reports the approximate degree to which delirium and functional decline practices are being implemented across organizations. Where possible, all sections include LHIN-level results for 2011, as well as current province-level results. In addition, each section describes overall levels of accomplishment and identifies promising practices. Note that the practices highlighted in this report may be occurring in a small number or even a single organization. Finally, each section of the report provides recommendations for ongoing organization- and LHIN-level planning.
In a Senior Friendly Hospital, leadership is committed to deliver an optimal experience for frail seniors as an organizational priority. This commitment empowers the development of human resources, policies and procedures, caregiving processes, and physical spaces that are sensitive to the needs of frail patients.
In a Senior Friendly Hospital, care is designed from evidence and best practices that are mindful of the physiology, pathology and social science of aging and frailty. Care and service across the organization are delivered in a way that is integrated with the health care system and support transitions to the community.

### Processes of Care

#### Accomplishments and Promising Practices in Delirium

In 2011, 60% of South West LHIN hospitals reported having a protocol/policy to address delirium. Currently, 81% of hospitals report having screening processes for delirium, and 75% have prevention and management procedures in place. Sixty-nine percent of hospitals have monitoring and evaluation of delirium. Hospitals are gradually spreading these practices across their organizations, with two hospitals having organization-wide screening, and one having prevention, management, and monitoring processes in place organization-wide. Specific promising practices related to delirium include:

- All admitted patients 65 and older are screened for delirium, dementia, and depression in some hospitals.
- Delirium screening is integrated into standard admission assessments. Positive screens for delirium trigger medical orders and further diagnostic testing.
- The Confusion Assessment Method (CAM) is used to screen all admitted patients every day at a standardized time. Positive screens trigger a care plan with follow-up assessments and interventions.
- Strategic clinical services renewal includes implementation of the Hospital Elder Life Program and P.I.E.C.E.S. and Gentle Persuasive Approaches training for nursing staff.
- Education of nursing staff on delirium and use of the CAM. Participation in provincial SFH indicators pilots has increased staff capacity.
- Implementation of the CAM on electronic health records.

#### DELIRIUM – % of hospitals with any degree of implementation of indicated practice

<table>
<thead>
<tr>
<th></th>
<th>2011 South West LHIN</th>
<th>2014 South West LHIN</th>
<th>2014 Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Detection</td>
<td>60*</td>
<td>81</td>
<td>92</td>
</tr>
<tr>
<td>Prevention and Management</td>
<td>75</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Monitoring and Evaluation</td>
<td>20</td>
<td>69</td>
<td>86</td>
</tr>
</tbody>
</table>

* Reported “Yes” to having a protocol/policy in place for delirium

#### Progress toward organization-wide implementation in South West LHIN hospitals (n=16)

<table>
<thead>
<tr>
<th></th>
<th>Number of Hospitals with Indicated Degree of Implementation (% of Patient Care Units)**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Screening and Detection</td>
<td>0%</td>
</tr>
<tr>
<td>Prevention and Management</td>
<td>4</td>
</tr>
<tr>
<td>Monitoring and Evaluation</td>
<td>5</td>
</tr>
</tbody>
</table>

** Excludes patient care units that do not include older adults (e.g. neonatal, maternity)
In a Senior Friendly Hospital, care is designed from evidence and best practices that are mindful of the physiology, pathology and social science of aging and frailty. Care and service across the organization are delivered in a way that is integrated with the health care system and support transitions to the community.

### Processes of Care

**FUNCTIONAL DECLINE – % of hospitals with any degree of implementation of indicated practice**

<table>
<thead>
<tr>
<th></th>
<th>2011 South West LHIN</th>
<th>2014 South West LHIN</th>
<th>2014 Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Detection</td>
<td>40*</td>
<td>69</td>
<td>89</td>
</tr>
<tr>
<td>Prevention and Management</td>
<td>63</td>
<td>69</td>
<td>75</td>
</tr>
<tr>
<td>Monitoring and Evaluation</td>
<td>10</td>
<td>63</td>
<td>84</td>
</tr>
</tbody>
</table>

* Reported “Yes” to having a protocol/policy in place for functional decline

**Progress toward organization-wide implementation in South West LHIN hospitals (n=16)**

<table>
<thead>
<tr>
<th></th>
<th>Screening and Detection</th>
<th>Prevention and Management</th>
<th>Monitoring and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hospitals with Indicated Degree of Implementation (%) of Patient Care Units**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>5</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>H</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>H</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>H</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>H</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Excludes patient care units that do not include older adults (e.g. neonatal, maternity)**

### Accomplishments and Promising Practices in Functional Decline

Current environmental scan results show that South West LHIN hospitals are paying increased attention to functional decline. In 2011, 40% of hospitals reported having a protocol/policy for functional decline. Presently, 69% of hospitals have implemented screening processes, while 63% report having prevention, management, and monitoring procedures related to functional decline. Most hospitals have not yet progressed to organization-wide implementation. Specific promising practices include:

- Clinical services renewal includes participation in the Mobilization of Vulnerable Elders in Ontario (MOVE ON) program to enhance early mobilization.
- A new patient care exercise program has been implemented to reduce functional decline.
- A Functional Decline Working Group is in place and is developing a standard bedside whiteboard communication strategy for mobilization of patients.
- Falls risk assessment is completed on all patients using the Morse Falls Scale.
- Intentional Comfort Rounding, Safety Crosses, and post-fall huddles were implemented with a 25% reduction in fall-related injuries.
- Use of the Barthel Index to measure ADL function for all physiotherapy episodes of care at two hospital sites.
- Use of the Health Outcomes for Better Information and Care (HOBIC) ADL assessment tool with good compliance at patient admission and efforts to improve compliance at patient discharge. Change in ADL function is reported monthly by site on a scorecard reported to the hospital board.
- Telephone follow-up of patients 24-48 hours after discharge to assess functional ability and initiate referrals for support as required.
Promising Practices in Transitions in Care

While standardized best practices to optimize transitions in care are not yet fully defined, many promising practices supporting care transitions have been implemented. These include the following specific initiatives or general practices:

- Early risk identification in emergency departments using standard tools – such as the Blaylock Discharge Planning Risk Assessment, Complex Discharge Screening Tool, and CCAC e-Screener – in some cases supporting direct admissions to a medicine unit.
- Standard tools and processes, such as transfer of accountability checklists, are in place for inter-unit and inter-facility transfer of patient information.
- Collaborative discharge planning meetings with community partners. These include Community Care Access Centres (CCACs); Family Health Teams; long-term care homes; assisted living facilities; Behavioural Supports Ontario Geriatric Outreach Team; and Alzheimer’s Society.
- An electronic health record is shared with other hospitals in the region. Community Care Access Centre coordinators also chart in electronic health records, allowing hospital staff to review discharge plans.
- Standard discharge checklist for information transfer to long-term care homes.
- The Geriatric Mental Health Team helps prepare patients for transitions by simulating the care environment of the discharge destination. Follow-up and transition support is provided by the Mental Health Ambulatory Geriatric Program.
- Implemented the Home First and Home at Last Programs to engage community support prior to patient discharge.
- A Geriatric Day Hospital offers tours of their outpatient facilities and books initial appointments before patients are discharged from the geriatric and musculoskeletal rehabilitation areas of the hospital.
- A “moving team” in a veterans’ care program provides practical and emotional support to residents changing unit locations.
- Telephone follow-up by a registered nurse 24-48 hours post-discharge to identify and provide support for challenging issues.
- When needed, follow-up appointments with patients’ family doctors are booked prior to hospital discharge.

Recommendations

- The majority of delirium care practices are not yet implemented organization-wide. Continued spread of these practices to all relevant clinical areas is recommended. This includes the emergency department where early detection and intervention might be achieved.
- Hospitals should embed documentation of delirium in care records to support compliance, monitoring, and transfer of information during transitions across the organization.
- Hospitals should continue to monitor compliance and accuracy of delirium screening.
- Implementing indicators across the system would help support the continued monitoring and evaluation of practice addressing delirium.
- The majority of practices for preventing functional decline, such as early mobilization strategies, are not yet implemented organization-wide. Continued spread to all relevant clinical areas – including the emergency department – is recommended.
- Further system-wide planning to develop indicators for functional decline practice in acute care is needed for ongoing monitoring and compliance.
- Standardized education on delirium and functional decline should be available to all hospital staff. Resources and tools should be shared at the LHIN and provincial levels.

In a Senior Friendly Hospital, care is designed from evidence and best practices that are mindful of the physiology, pathology and social science of aging and frailty. Care and service across the organization are delivered in a way that is integrated with the health care system and support transitions to the community.
In a Senior Friendly Hospital, care and service are provided in a way that is free of ageism and respects the unique needs of patients and their caregivers. This maximizes quality and satisfaction with the hospital experience.

Accomplishments and Promising Practices

Hospitals in the South West LHIN are beginning to develop an awareness of seniors’ needs in their patient experience processes. Just over half of hospitals offer seniors-sensitivity training. Sixty-nine percent of hospitals incorporate a senior-friendly lens in quality improvement initiatives, while 75% apply this awareness to patient-centred care and diversity practices. Specific promising practices include:

- A family resource room was created in ambulatory care areas, providing information related to accessing community resources.
- A Patient and Family Experience Framework is under development.
- Visiting hour restrictions have been removed.
- A presentation on senior-friendly approaches to care has been provided during professional practice rounds, broadcast live to all hospital sites.
- Policy additions have been made to honour Aboriginal Traditions.

Recommendations

- Seniors-sensitivity training remains an important educational need for both clinical and non-clinical staff, and organizations offer curriculum in different ways. Collaborative planning across the LHIN may help determine specific educational needs and build on existing and impactful training to promote shared learning in this domain of senior-friendly hospital care.
- SFH principles should be incorporated more fully into quality and patient experience initiatives. All hospitals should work toward incorporating a senior-friendly lens and awareness of seniors’ needs in all quality, patient-centred care, and diversity practices.
In a Senior Friendly Hospital, care is provided and research is designed in a way that protects the autonomy, choice, and diversity of the most vulnerable of patients.

**Accomplishments and Promising Practices**

As in 2011, policies and structures supporting ethical issues are mostly in place. All South West LHIN hospitals have processes to support advance care planning. Fifteen report having an ethicist or ethics consultation team, and processes for capacity and consent. Thirteen hospitals have processes to address suspected elder abuse. Specific promising practices include:

- A Quality Ethics Decision-Making Framework has been developed and endorsed by the board of directors.
- Rollout of revised ethics policies and procedures. This includes education in the form of case-based discussions and an e-learning package.
- A corporate ethics committee has been established and has guided the development of new educational materials on capacity and consent. A new resuscitation care process is being developed.
- Revised advance care planning policies to ensure a range of options are available and discussed with patients and their families.

**Recommendations**

- While many ethical supports are in place, ethical issues in patient care can be extremely complex. All hospitals are encouraged to provide continued education such as case presentations and lunch-and-learns to help staff remain mindful of potentially challenging situations and of appropriate actions when these issues arise.
- Three hospitals in the region have yet to develop processes for Elder Abuse. LHIN-wide sharing of elder abuse protocols implemented by hospitals may improve practice in this domain and support appropriate referral and access to ethics resources in the region.

---

**ETHICS IN CLINICAL CARE AND RESEARCH – % of hospitals with practice/structure in place**

<table>
<thead>
<tr>
<th></th>
<th>2011 South West LHIN</th>
<th>2014 South West LHIN</th>
<th>2014 Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethicist or Ethics Consultation Service</td>
<td>100 (100%)</td>
<td>94 (93%)</td>
<td>93 (93%)</td>
</tr>
<tr>
<td>Processes for Capacity and Consent</td>
<td>n/a</td>
<td>94 (93%)</td>
<td>97 (97%)</td>
</tr>
<tr>
<td>Processes for Advance Care Planning</td>
<td>93 (93%)</td>
<td>100 (100%)</td>
<td>93 (93%)</td>
</tr>
<tr>
<td>Processes for Elder Abuse</td>
<td>n/a</td>
<td>81 (81%)</td>
<td>87 (87%)</td>
</tr>
</tbody>
</table>

**Extent of practice/structure in South West LHIN hospitals (n=16)**

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Unit/Dept Specific</th>
<th>Organization Wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethicist or Ethics Consultation Service</td>
<td>1</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Processes for Capacity and Consent</td>
<td>1</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Processes for Advance Care Planning</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Processes for Elder Abuse</td>
<td>3</td>
<td>0</td>
<td>13</td>
</tr>
</tbody>
</table>
In a Senior Friendly Hospital, the structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of frail patients, promoting safety, comfort, independence, and functional well-being.

**Physical Environment**

**Significant improvement has been made in the Physical Environment domain. In 2011, 13% of South West LHIN hospitals conducted periodic environment audits using Senior Friendly design principles. Presently 69% of hospitals have conducted such audits, and a similar number have incorporated SFH design resources into aspects of their physical environment planning. Specific promising practices include:**

- Completed organization-wide audits of existing structures using Code Plus guidelines in 2011 and 2013. Audits will continue to be performed every two years.
- Developed a plan to upgrade the physical environment to conform to Code Plus guidelines by 2017.
- A consultation process involved families and visitors in selecting bedside chairs for geriatric and musculoskeletal rehabilitation units.
- Patients were involved in selecting paint colors for upgrades on Acute Care for Elders units.
- White boards at the bedside to promote communication about patients’ mobility levels and assistance required.
- Environmental upgrades include: paint colours, flooring modifications, improved signage, and analog clocks.
- Senior tracer audits were conducted using a senior-friendly lens. This involved participation of a board member and a hospital volunteer over the age of 65.
- Use of technology (e.g., Skype, i-Pads, Smart Boards, pocket talkers, and DUO communication systems) to support communication in patient care areas.

**Accomplishments and Promising Practices**

<table>
<thead>
<tr>
<th>SFH Environmental Audits</th>
<th>2011 South West LHIN</th>
<th>2014 South West LHIN</th>
<th>2014 Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFH Incremental Environmental Upgrades</td>
<td>n/a</td>
<td>63</td>
<td>82</td>
</tr>
<tr>
<td>SFH in Planning of Large Constructions</td>
<td>n/a</td>
<td>69</td>
<td>79</td>
</tr>
<tr>
<td>SFH in Capital/Small Equipment Purchases</td>
<td>n/a</td>
<td>69</td>
<td>82</td>
</tr>
<tr>
<td>SFH in Environmental Maintenance</td>
<td>n/a</td>
<td>69</td>
<td>73</td>
</tr>
</tbody>
</table>

**Recommendations**

- SFH design can be executed with cost-neutral impact and with benefit to patient safety and comfort. All hospitals should continue to incorporate SFH design resources in addition to accessibility and building code when planning new and incremental upgrades to their physical environment.
In their self-assessment responses, hospitals identified a number of LHIN- or system-wide supports needed to enable SFH care in the region.

The majority of hospitals in the South West LHIN expressed an interest in participating in a LHIN-based SFH working group or committee to share and, where possible, standardize best practices, tools, and resources. Hospitals also expressed their desire to collaborate across the LHINs to network and learn from other hospitals with similar practice environments. Hospitals would also benefit from a LHIN-wide Seniors’ Strategy that integrates South West senior-friendly initiatives into a plan that aligns with the Ontario Seniors’ Strategy. The convening of formalized structures and relationships to promote this shared learning and collaboration is recommended. Support from the LHIN for the continuation of a SFH consultant role through 2017 will help facilitate this networking and advance the regional SFH strategy.

Hospitals request support and funding to ensure that dedicated resources are available to develop, implement, and evaluate SFH initiatives. In particular, funding was requested to develop processes and practices that target delirium and functional decline – including support for the Hospital Elder Life Program and the implementation of electronic screening processes. Hospitals encouraged the LHIN to advocate for funding from the Ministry of Health and Long-Term Care to support and sustain these important initiatives.

Education and capacity building remain important needs in the region. The most immediate educational needs were identified as: geriatric giants training (e.g., delirium, dementia, nutrition, pain management, mobility, falls, and polypharmacy); capacity and consent procedures; skills to manage responsive behaviours (e.g., Gentle Persuasive Approaches and crisis intervention training); and seniors-sensitivity training. System-wide planning and, where possible, standardization of education curriculum may help avoid redundancies while addressing these common learning needs.
Hospitals in the South West LHIN have made good progress in their commitment towards SFH care since 2011, though significant work remains to be accomplished.

Compared to the environmental scan results of 2011, South West LHIN hospitals are reporting increased uptake of practices and structures in most domains of the SFH framework. Most hospitals have established committee structures for SFH implementation and have identified administrative leadership for senior-friendly care. More formal SFH commitments in hospital strategic plans, board of director agendas, or formal quality improvement plans is encouraged. Importantly, hospitals have demonstrated increasing attention toward the clinical priorities of delirium and functional decline. Presently, 81% of hospital in the LHIN have some degree of practice addressing delirium, and 69% report practices addressing functional decline.

While these clinical practices have been initiated across the LHIN, there remains significant opportunity for spread and scale of successful implementations within organizations. The progression to organization-wide implementation and high levels of compliance with delirium and functional-decline practices remains an important target for improvement. Standardized education and LHIN-wide collaboration to share knowledge, resources, and successful implementation strategies is encouraged. Implementing SFH indicators for delirium across the system can help monitor continued uptake and compliance with practice.

Hospitals are encouraged to review the recommendations included under each domain in this report. Becoming a senior-friendly organization requires more than implementing a series of initiatives. It is a long-term commitment that integrates each of the five domains of the senior-friendly hospital framework. Senior-friendly hospitals deliver care that maximizes the potential for older patients to transition safely through the continuum of care and return to their homes. By providing an optimal care experience while improving health outcomes, senior-friendly hospitals are a key enabler in Ontario’s health care system.
Acknowledgements

REPORT AUTHORS

Ken Wong, Ada Tsang, and Barbara Liu
Regional Geriatric Program of Toronto

SENIOR FRIENDLY HOSPITAL 2014 ENVIRONMENTAL SCAN WORKING GROUP

Barbara Liu (Chair)  Regional Geriatric Program of Toronto
Ada Tsang  Regional Geriatric Program of Toronto
Ken Wong  Regional Geriatric Program of Toronto
Rhonda Schwartz  Central East Seniors’ Care Network
Jennifer McKenzie  North East Local Health Integration Network
Elizabeth McCarthy  Regional Geriatric Program of Southwestern Ontario
Tamara Nowak-Lennard  North Simcoe Muskoka Local Health Integration Network
Sandi Homeniuk  North West Local Health Integration Network
Simmy Wan  Central Local Health Integration Network
Mary Kay McCarthy  University Health Network

SOUTH WEST LHIN SENIOR FRIENDLY HOSPITAL LEADS

Julie Girard
Christina Janson
Kristy McQueen
Jennifer McCullough