Senior Friendly Hospital Care in the
Toronto Central 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). 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. Thirteen Toronto Central LHIN hospitals completed the self-assessment survey. These are: Baycrest, Bridgepoint Active Healthcare, the Centre for Addiction and Mental Health, Mount Sinai Hospital, Providence Healthcare, Runnymede Healthcare Centre, the Salvation Army Toronto Grace Health Centre, St. Joseph’s Health Centre, St. Michael’s Hospital, Sunnybrook Health Sciences Centre, Toronto East General Hospital, University Health Network (Toronto Rehab and Toronto Western Hospital sites), and West Park Healthcare Centre.

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

All hospitals have at least some degree of implementation of delirium care processes which is a significant improvement compared to 2011. More than half of the hospitals in the Toronto Central LHIN report organization-wide implementation of delirium screening protocols. Almost all hospitals identified behaviours in older patients as a challenge for clinical care and for discharge planning. While it is clinically important to distinguish between delirium and dementia, care approaches for behavioural symptoms in either condition are similar. Specific accomplishments and promising practices in delirium and responsive behaviours include:

- Mandatory organization-wide education on prevention, early recognition and management of delirium.
- Videos, handheld apps and e-learning modules have been developed to support the implementation of the Confusion Assessment Method (CAM) and CAM – Intensive Care Unit across a multi-site organization.
- Delirium screening is built into electronic medical records along with a “HANDOVER” prevention protocol. Compliance with screening is monitored.
- Screening for the 3D’s occurs within 24 hours of admission and is monitored for compliance. Screening leads to implementation of person-centred, evidence-informed care tailored for older persons with cognitive impairment.
- Pre-printed orders and standard care plans have been developed for delirium.
- Accountability indicators for hospital-acquired delirium are in place and being monitored.
- Inter-professional psychogeriatric service is integrated with other medical services. Similarly, the Safe Patients/Safe Staff program provides a behavioural rapid response team.
- Standard tools and multimodal education supports the assessment and management of responsive behaviours. Gentle Persuasive Approaches education is delivered to staff.

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

<table>
<thead>
<tr>
<th></th>
<th>2011 Toronto Central LHIN</th>
<th>2014 Toronto Central LHIN</th>
<th>2014 Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Detection</td>
<td>80*</td>
<td>100</td>
<td>92</td>
</tr>
<tr>
<td>Prevention and Management</td>
<td>100</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Monitoring and Evaluation</td>
<td>53</td>
<td>100</td>
<td>86</td>
</tr>
</tbody>
</table>

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

#### Progress toward organization-wide implementation in Toronto Central LHIN hospitals (n=13)

<table>
<thead>
<tr>
<th></th>
<th>H</th>
<th>H</th>
<th>H</th>
<th>H</th>
<th>H</th>
<th>H</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Detection</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention and Management</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring and Evaluation</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td></td>
<td></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

Overall, there is increased attention to functional decline compared to 2011. All Toronto Central LHIN hospitals have implemented early mobilization or other strategies to prevent functional decline, and many have spread these practices organization-wide. In some hospitals, practice to prevent functional decline is included as a corporate standard or in a formal quality improvement plan. Compared to practice addressing delirium, Toronto Central LHIN hospitals are taking more varied approaches toward functional decline. Specific accomplishments and promising practices include:

- Daily assessment of older patients for functional decline.
- Acute Care for Elders (ACE) tracker software provides a real-time dashboard to screen at-risk patients 65 years of age and older.
- The “First Three Days” initiative uses standard tools to identify at-risk seniors, initiate comprehensive geriatric assessment, and continue inter-professional intervention between unit transfers. This initiative has decreased acute length of stay by 1.4 days and improved mobility rates by 60%.
- Successful recruitment of geriatrics-trained health professionals; enhanced access to geriatric assessment; a new Acute Care for Elders unit; and integration of multiple initiatives all contribute to senior friendly accomplishments addressing functional decline. These include: use of the Maximizing Aging Using Volunteer Engagement (MAUVE) program, early mobilization protocols, and up-for-meals care standards.
- Innovative strategies to recognize staff engagement, such as the “One small step for patients, one giant step for patient care” award winning slogan; and the integration of volunteers in strategies for the prevention of functional decline.
- Addressing bladder and bowel continence and monitoring outcomes on a clinical indicator report.

Accomplishments and Promising Practices in Functional Decline
Processes of Care

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:

- Transfer of accountability at shift change occurs at the bedside with engagement of patient and families. A standardized checklist is used and a bedside safety check is performed.
- Using a “Ticket to Ride” decision tree and checklist to keep patients safe during transport from inpatient to procedure areas.
- A system navigator is on staff for high-risk seniors.
- Community health navigators follow-up older patients with a telephone call 48 hours after discharge and at one month.
- Weekly meetings with the Community Care Access Centre and inpatient leaders.
- Expanded GEM coverage in the ED including weekends and evenings.
- Integrated partnerships with community centres to provide post-rehabilitation community-based exercise programs; outpatient stroke programs; and a falls-prevention exercise program.
- Integration of clinical services with external partners. Examples include the Integrated Care for Complex Populations (ICCP) program; virtual ward; house calls; Health Links; the Seamless Care Optimizing the Patient Experience (SCOPE) pilot; acute and post-acute hospital partnerships; and nurse-led outreach (NLOT).
- A “Hit the Dirt Running” program works with upstream partners to ensure early intervention focusing on functional and rehabilitative needs of vulnerable patients.

Recommendations

- There has been good progress in targeting the SFH clinical priorities of delirium and functional decline. 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.
- 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, while still allowing the tailoring of procedures to meet specific organizational needs and contexts.
- 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 to support the monitoring and evaluation of practice addressing delirium.
- Further system-wide planning to develop indicators for functional decline practice in acute care is needed for ongoing monitoring and compliance.

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.

**Emotional and Behavioural Environment**

Most hospitals have delivered education on seniors-sensitivity. This is an organization-wide commitment in more than half of Toronto Central LHIN hospitals. In at least one organization, aging awareness education for all hospital staff includes service, finance, health records, admitting, and food services staff.

Investment in the education of clinical and non-clinical staff in several organizations. An example of non-clinical staff engagement is the participation of environmental services and logistics staff championing customer service for seniors and finding ways to enhance the physical environment.

Geriatrics-specific professionals are embedded in all major hospital committees and initiatives to provide a senior-friendly lens.

Alignment with other related initiatives in diversity, spirituality and equity. Education on seniors with mental health – the “double stigma”.

Patient satisfaction data is age-stratified. Each program is asked to develop a quality improvement project to address the satisfaction of older patients.

Use of tablets to improve access to a client experience survey.

Patient and family advisory councils in several hospitals.

A patient navigator role that aims to improve the patient experience.

**Accomplishments and Promising Practices**

<table>
<thead>
<tr>
<th>Emotion and Behavioural Environment – % of hospitals with practice/structure in place</th>
<th>2011 Toronto Central LHIN</th>
<th>2014 Toronto Central LHIN</th>
<th>2014 Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seniors Sensitivity Training</td>
<td>n/a</td>
<td>85</td>
<td>68</td>
</tr>
<tr>
<td>SFH Lens Applied to Quality Improvement</td>
<td>53</td>
<td>85</td>
<td>74</td>
</tr>
<tr>
<td>SFH Lens Applied to Patient-Centred Care/Diversity Practices</td>
<td>40</td>
<td>92</td>
<td>77</td>
</tr>
</tbody>
</table>

**Recommendations**

- Many SFH principles have been incorporated throughout quality and patient experience initiatives. However, seniors-sensitivity training remains an important educational need. Toronto Central LHIN hospitals should continue to spread this education organization-wide and include non-clinical staff. Collaborative planning across the LHIN to build on existing training curricula may promote shared learning in this domain of senior-friendly hospital care.

- Continue to leverage and integrate work in related areas such as diversity, patient-centredness and the patient experience.

- Review patient satisfaction data that is age-stratified.

- Spread use of patient and family advisory councils to all hospitals. LHIN-wide collaboration and planning may help refine effective and meaningful methods of engaging a variety of seniors’ perspectives.
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.

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

<table>
<thead>
<tr>
<th></th>
<th>2011 Toronto Central LHIN</th>
<th>2014 Toronto Central LHIN</th>
<th>2014 Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethicist or Ethics Consultation Service</td>
<td>100</td>
<td>100</td>
<td>93</td>
</tr>
<tr>
<td>Processes for Capacity and Consent</td>
<td>n/a</td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td>Processes for Advance Care Planning</td>
<td>79</td>
<td>92</td>
<td>93</td>
</tr>
<tr>
<td>Processes for Elder Abuse</td>
<td>n/a</td>
<td>100</td>
<td>87</td>
</tr>
</tbody>
</table>

**Extent of practice/structure in Toronto Central LHIN hospitals (n=13)**

<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>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Processes for Capacity and Consent</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Processes for Advance Care Planning</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Processes for Elder Abuse</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
</tbody>
</table>

**Accomplishments and Promising Practices**

As in 2011, policies and structures supporting ethical issues are largely in place across the region. All hospitals report having an ethicist or ethics consultation team; processes for capacity and consent; and procedures to address suspected elder abuse. Most hospitals have a formal process to support advance care planning. Specific promising practices include:

- A Clinical Ethics Decision Making Framework policy and process was created and is available to all staff.
- Internal Geriatric Consult Team provides consultation, identifying elder abuse issues and advocating for community follow-up after hospital discharge.
- A new advance directives process was rolled out in fall 2014. An education campaign ensures that staff, clients, residents, and family members are aware of the new policy and procedures.
- A new “Plan for Life Sustaining Treatment (PLST)” order form was developed.
- Advance Care Planning (ACP) Workshop for healthcare professionals has developed 29 ACP Champions to date.
- An Elder Abuse Intervention Model has been developed to assist staff in identifying a proper course of action if elder abuse is suspected.

**Recommendations**

- While many ethical supports are in place, ethical issues in patient care can be extremely complex. Continued education such as case presentations and lunch-and-learns are encouraged to help staff remain mindful of potentially challenging situations and of appropriate actions when these issues arise.
- LHIN-wide sharing of ethics procedures implemented by hospitals – such as advance care planning and elder abuse protocols – may improve practice in this domain and support appropriate referral and access to ethics resources in the region.
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.

<table>
<thead>
<tr>
<th>Physical Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource kits are provided to the Planning and Facilities department and the Accessibility Committee to ensure that new builds and renovations are aligned with senior-friendly principles.</td>
</tr>
<tr>
<td>Clinical staff, such as a neuroscientist, are engaged in the design and development of physical spaces.</td>
</tr>
<tr>
<td>A set of outcome measures to evaluate new hospital facilities was informed by a research collaboration.</td>
</tr>
<tr>
<td>New purpose-built hospital structures are designed to promote independence, safety, and dignity in performing activities of daily living.</td>
</tr>
<tr>
<td>Use of an audit tool, based on Code Plus standards, to review 88 areas of the hospital. Unit managers report twice a year on progress made on the recommendations.</td>
</tr>
<tr>
<td>The hospital is working with the Patient/Family Advisory Council to identify environmental challenges facing patients and their families and visitors, especially during the winter months and weekends.</td>
</tr>
<tr>
<td>Short-term drop off locations have been created close to building entrances.</td>
</tr>
<tr>
<td>Elevator lobby areas are prioritized for the installation of rest stops.</td>
</tr>
<tr>
<td>A senior-friendly seating selection guide is distributed to all clinical areas.</td>
</tr>
<tr>
<td>All hospital beds are low profile beds with built-in bed alarms.</td>
</tr>
<tr>
<td>Dining rooms have been created on every unit to promote socialization and cognitive stimulation.</td>
</tr>
<tr>
<td>Customized gyms have been created on every floor, providing easy access to tailored rehabilitation programs.</td>
</tr>
<tr>
<td>A unit with dementia-friendly design is being developed. A literature review is informing the design of a senior-friendly ambulatory care centre.</td>
</tr>
</tbody>
</table>

**Accomplishments and Promising Practices**

**Recommendations**

- SFH design can be executed with cost-neutral impact and with benefit to patient safety and comfort. All hospitals should incorporate SFH design resources in addition to accessibility and building code when planning both 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.

Twelve hospitals in the Toronto Central LHIN expressed interest or are already participating in a LHIN-based SFH network to share and, where possible, standardize best practices, tools, and resources. Hospitals also suggested region-wide mandating of SFH quality improvement plans and inclusion of SFH care in strategic priorities. It was further suggested that elements of SFH care should be developed as accreditation standards.

Support and funding was requested to ensure that dedicated resources were available to develop, implement, and evaluate SFH initiatives and education. With respect to education, the most immediate needs were identified as: geriatric giants training (e.g., delirium, dementia, nutrition, pain management, polypharmacy, mobility, and falls); capacity and consent procedures; skills to manage responsive behaviours (e.g., Gentle Persuasive Approaches and crisis intervention protocols), seniors-sensitivity training; and quality improvement methodologies. System-wide planning and, where possible, standardization of education curricula may help avoid redundancies while addressing these common learning needs.

Hospitals would also benefit from a framework or additional direction from the LHIN to guide transitions in care and discharge planning. Some examples of needed resources include: improving system navigation support for patients and families; increasing community supports and post-acute care options for patients with responsive behaviours; and establishing partnerships or collaborations between organizations to ensure optimal transitions. Furthermore, hospitals encouraged funding to appropriately resource Assess and Restore strategies that would support aging at home.

The availability of clinical data was also identified as an important need. Hospitals providing complex continuing care request support to implement electronic health records and obtain data more readily from external sources (e.g., Cancer Care Ontario, Canadian Institute of Health Information).
Hospitals in the Toronto Central 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, Toronto Central LHIN hospitals are reporting increased uptake of practices and structures in all five domains of the SFH framework. Presently, all hospitals have SFH commitments in their strategic plans and formal quality improvement plans. Most have also identified administrative and clinical leadership for SFH care. Most importantly, hospitals have focused more attention on the clinical priorities of delirium and functional decline. Presently, all hospitals in the Toronto Central LHIN report practices that address delirium and functional decline, and there has been significant progress in moving these practices to an organization-wide scale.

With these clinical practices largely initiated across the LHIN, hospitals are encouraged to continue expanding their successful implementations. 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 success 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

TORONTO CENTRAL LHIN SENIOR FRIENDLY HOSPITAL LEAD

Shehnaz Fakim