A Summary of Senior Friendly Care in Central East LHIN Hospitals

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

In the summer of 2010, the Toronto Central Local Health Integration Network (TC LHIN) assembled a Senior Friendly Hospital Strategy Task Group to provide guiding steps toward the improvement of seniors’ health and well-being by reducing their functional decline in hospitals. The efforts of this task group laid the groundwork for the Ontario Senior Friendly Hospital Strategy, and resulted in a summary report of senior friendly hospital care in the TC LHIN. The report identified common themes, promising practices, and areas for improvement at the hospital and system levels.

In order to incorporate this work into the provincial strategy, the remaining thirteen LHINs in Ontario have conducted a similar process so that the provincial landscape of senior friendly hospital care may be surveyed.

A healthy seniors’ population builds and sustains healthy communities. The care that seniors receive in hospitals, and the hospital experience itself, are among the key determinants in the health and well-being of older adults.

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.

A senior friendly hospital is one in which the environment, organizational culture, and care-giving processes accommodate and respond to seniors’ physical and cognitive needs, promote good health (e.g. nutrition and functional activation), maximize safety (e.g. preventing adverse events), and involve patients – along with families and caregivers – to be full participants in their care. The aim is to enable seniors to regain their health after their hospital stay is complete and transition to the next level of care that best meets their needs, whether it is post-acute care, community care, or long-term care. The Ontario Senior Friendly Hospital Strategy will:

- Improve the health, well-being, and experience of seniors in Ontario hospitals, thereby supporting decreased lengths of stay
- Improve the capacity for older adults to live independently and thereby reduce hospital readmission rates
- Result in a better use of health care dollars

The first step in the Ontario Senior Friendly Hospital Strategy involved the completion of a self-assessment by hospital organizations and the generation of a regional summary report to identify promising senior friendly care initiatives, potential gaps, and opportunities for coordinated action.

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1. The Regional Geriatric Program of Toronto (2010). A Summary of Senior Friendly Care in Toronto Central LHIN Hospitals. Toronto: Toronto Central Local Health Integration Network.
The Regional Geriatric Program (RGP) of Toronto produced a background document titled *Senior Friendly Care in Toronto Central LHIN Hospitals* as well as an accompanying *Self-assessment Template*. The latter document was subsequently modified and both were distributed by the LHINs to their member hospital organizations. The documents were based on the RGPs of Ontario-endorsed Senior Friendly Hospital Framework, which is composed of five interrelated domains: organizational support, process of care, emotional and behavioural environment, ethics in clinical care and research, and physical environment.

This summary report of the Central East LHIN (CE LHIN) hospital self-assessments represents a point in time snapshot of senior friendly hospital care in the LHIN. It identifies strengths as well as areas for improvement in CE LHIN hospitals, in an effort to help envision and build a system that promotes the independence of seniors and the provision of high quality care for older adults. It also identifies an array of practices and programs in CE LHIN hospitals that are promoting senior friendly care. These could be considered as models for broader adoption.

Seniors utilize a significant portion of hospital resources in the Central East LHIN. The LHIN’s hospital organizations report, on average, that 58% of their total hospital days are attributable to older patients. Moreover, they report that an average 81% of alternate level of care (ALC) days are attributable to seniors. A substantial body of evidence shows that the hospital stay itself puts seniors at risk for complications and loss of functional ability, thereby contributing to longer lengths of stay and ALC. It has been estimated that one-third of frail seniors lose independent function as a result of hospital practices, half of whom are unable to recover the function they lost.\(^3\,4\)

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 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 CE LHIN will support its hospital organizations in adopting the Senior Friendly Hospital Framework and integrating measurable objectives into hospital service accountability agreements. This continuing work also provides concrete opportunities for hospitals to achieve their commitments within other overarching quality programs, and it will be

\(^2\) The Regional Geriatric Program of Toronto (2010). *Background Document: Senior Friendly Care in Toronto Central LHIN Hospitals*. Toronto: Toronto Central Local Health Integration Network.


important to consider alignment with indicators related to the Excellent Care for All Act, the Canadian Patient Safety Institute (CPSI), and accreditation processes.

Results from the CE LHIN hospital self assessments reflect the degree to which senior friendly care is prioritized by its hospital organizations. All hospital organizations in the LHIN have or are in the process of establishing senior friendly goals within their strategic plans, and seven have designated a senior executive to lead relevant activities. Two hospitals have established formal committees to guide the development of eldercare services, and two are in the process of forming similar structures. Four CE LHIN organizations also describe Community Advisory Committees designed to solicit public feedback. A number of educational initiatives support the development of frailty-focused skills in organizations’ human resources. These initiatives include selected senior friendly learning goals built into the orientation of clinical staff, and more comprehensive elder friendly training provided organization-wide to both clinical and non-clinical employees. Peer leadership is also supported, whereby geriatrics champions within organizations facilitate continuing learning and lead improvement processes. Organizational leadership, a commitment to developing human resource skills in geriatrics, and the engagement of community partners in health service planning are positive steps toward improved system integration that will better serve seniors and other frail populations.

The self-assessment analysis also examined clinical processes of care that are particularly relevant to seniors admitted to hospital. Falls, restraint use, and pain management are the clinical areas most often reported to have developed protocols and/or formal monitoring. In contrast, continence, hydration/nutrition, sleep management, elder abuse, and the management of dementia-related behaviours were the clinical areas least often managed with protocols or monitoring procedures. Education and practice that emphasize inter-professional teamwork and shared responsibility for functional outcomes in older patients are important to include in ongoing hospital plans. Hospitals also reported creative partnerships and inter-organizational collaboration in many promising practices. A significant initiative within the CE LHIN is the Geriatric Assessment and Intervention Network (GAIN) – clinics providing inter-professional, comprehensive geriatric assessment that work closely with emergency departments and Acute Care for Elders (ACE) units in hospital. They serve as important interfaces that facilitate supported transitions to the community or, for patients requiring acute hospital care, to ACE units, which are more appropriately configured for frail elderly patients. These practices are important in sustaining discharges from hospital, and support emergency departments in preventing avoidable admissions. Teamwork and partnership will be important enduring enablers required to support continuity in the health care system as a whole.

The hospital care experience is influenced by the emotional and behavioural climate of the organization. All hospitals indicated their support for patient-centred care and patient diversity. Some promising practices identified in this analysis include: bedside communication whiteboards, care conferences early in admission that promote patient and family engagement, discharge folders and other strategies that focus on patient education and empowerment, and a Cultural Competence Task Force. It is important that these types of practices are designed and delivered in a manner that
takes into account the unique needs of frail seniors, such as sensory and communication difficulties.

CE LHIN hospitals describe the resources they have in place to address ethical challenges that arise during the provision of care. Six organizations have an ethicist on staff to provide expertise and assistance during challenging ethical situations. One hospital has identified a priority to gain access to an ethicist, while the remaining two have a committee and consultation service to assist with ethical issues. The provision of ongoing education in ethics, including formal training sessions, an ethical decision making framework, and web-based resources, acknowledge the importance of ensuring that staff members are appropriately informed and supported in recognizing and responding to unique ethical situations as they arise in practice.

Aspects of the physical environment were cited by nearly all CE LHIN hospital organizations as creating barriers to the provision of senior friendly care. Many hospitals rely on building code standards and accessibility legislation to guide design and development of physical structures. There is a significant body of information regarding senior friendly environmental design5,6 with principles that go beyond generalized building code requirements or disability legislation outlined in the Accessibility for Ontarians with Disabilities Act (AODA). Four organizations have conducted, or are planning to conduct, audits of their physical spaces utilizing senior friendly resources. This has enabled organizations to prioritize requests for capital improvements, and in at least one organization, resulted in the implementation of design and equipment features that promote enhanced safety and comfort for older patients and visitors. Including clinical staff members and community representatives in physical environment audits is one way of incorporating relevant feedback into the design and planning process of capital development and upgrades. Since building improvements are long-term and costly undertakings, teams involved in developing, purchasing, and maintaining the physical facility should be informed of senior friendly design to promote the ongoing development of physical environments that meet the needs of seniors and other frail populations. This, in turn, will result in improved patient safety, comfort, and independence. If well implemented, redevelopment projects may also bring about work design efficiencies that allow staff to dedicate more time to direct patient care.

The current state of senior friendly hospital care in the Central East LHIN includes many promising practices as well as important opportunities for improvement. Hospitals in the LHIN identified the importance of health equity, patient-centred care, safety, medical ethics, and accessibility. These foundational principles have been present in hospitals for many years, often implemented in response to accreditation standards and, in the case of accessibility, through legislation. There is an opportunity to translate these core principles into specific strategies to more fully meet the needs of frail seniors. Identifying senior friendly care indicators will provide feedback to guide the

development and continued refinement of care and service across the system. Teamwork and partnerships were frequently highlighted as enablers of success, and will serve to enhance system integration and performance. Another key to achieving senior friendly care is the facilitation of knowledge sharing opportunities, so that hospitals across the Central East LHIN – and across the province – can learn from one another and work collaboratively to improve the quality of care for seniors across the hospital system.
2. The Ontario Senior Friendly Hospital Strategy in the Central East LHIN

2.1 BACKGROUND – THE SENIOR FRIENDLY HOSPITAL STRATEGY IN THE TORONTO CENTRAL LHIN

The Ontario Senior Friendly Hospital Strategy is an ongoing improvement initiative that aims to promote hospital practices that better meet the physical, emotional, and psychosocial needs of older adults. The Toronto Central Local Health Integration Network (TC LHIN) first supported local implementation of a Senior Friendly Hospital initiative as part of its commitment to enhancing the care of seniors within hospitals. In its Integrated Health Service Plan (IHSP-2) for 2010-2013, the TC LHIN identified a priority to reduce functional decline in seniors admitted to hospital. Enhancing the care of seniors in hospitals to increase their ability to transition safely back to the community is an essential component of an integrated, system-wide effort to reduce the time people spend waiting in emergency departments (ED) and alternate level of care (ALC) beds. Moreover, a systematic approach to improving hospitals’ environments and processes for seniors will strengthen their capacity to meet the quality and safety improvements required under the Excellent Care for All Act.

To guide work on this priority, the TC LHIN established a Senior Friendly Hospital Strategy Task Group in the summer of 2010 comprising representatives from acute, rehabilitation, and complex continuing care hospitals, as well as the Community Care Access Centre (CCAC). The Regional Geriatric Program (RGP) of Toronto was engaged as a partner to provide expert clinical consultation and to produce two guiding documents. The background document describes a five-domain Senior Friendly Hospital framework endorsed provincially by the RGPs of Ontario. This framework serves as a roadmap for quality improvement by defining key areas where hospital care of older adults can be optimized. The background document also describes the need for change, to ensure that the hospital experience is one that will enable positive outcomes for frail seniors. The self-assessment template, also structured on the Senior Friendly Hospital Framework, offers hospitals the chance to reflect on their environment, culture, and service delivery – and the role that all staff members share, from top level leadership to front line service and support staff. This self-assessment process resulted in a summary report, which helped to identify common themes in Senior Friendly Hospital care across the LHIN, including promising practices and opportunities for organization and system level improvement.

2.2 THE SENIOR FRIENDLY HOSPITAL STRATEGY IN THE CENTRAL EAST LHIN

The Central East LHIN has a rapidly growing and aging population. In particular, the 65-74 and 75-84 age groups are projected to have the fastest growth in numbers relative to the LHIN’s overall population, and are also expected to have the highest utilization of health care resources. The CE LHIN’s Integrated Health Service Plan (IHSP) for 2010-2013 has two strategic goals: the first is to reduce emergency department wait times, and the second is to decrease the impact of vascular

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The LHIN has embedded a focus on seniors’ health within its strategic goal targeting vascular disease, while the first objective – reducing emergency department wait times – is significantly impacted by the way hospital practices interface with the community. These objectives, along with the projected growth rate of seniors in the LHIN’s population, provide ample rationale to make the Senior Friendly Hospital Strategy a priority in supporting healthy communities in the CE LHIN.

A 2007-2008 profile of Aging in Ontario\(^9\) estimated that 17.1% of Central East LHIN’s population is comprised of older adults above age 65. This age cohort accounts for a significant proportion of hospital system usage in the LHIN. Hospital organizations across the LHIN report, on average, that 23% of ED visits, 58% of total hospital days, and 81% of ALC days are attributed to older adults (Figure 1). Considering the pace at which the seniors’ population in the CE LHIN is expected to grow, the pressures that exist now in managing hospital length of stay and ALC rates will only increase unless mitigating strategies are implemented.

The Senior Friendly Hospital Strategy is designed to inform senior leaders in hospitals about modifying the way care is organized and provided to older patients. Additionally, it is intended to emphasize the multiple dimensions of organizational change essential to achieving improved health outcomes for seniors. The Central East LHIN, through the provincial Senior Friendly Hospital Strategy, will support hospitals in adopting the Senior Friendly Hospital Framework and in integrating measurable objectives into hospital service accountability agreements. Moreover, the Senior Friendly Hospital Strategy provides concrete opportunities for hospitals to achieve commitments within the Excellent Care for All Act relevant to seniors.

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\(^{9}\) Institute for Clinical Evaluative Sciences (2010). Aging in Ontario: An ICES Chartbook of Health Service Use by Older Adults. Toronto: Institute for Clinical Evaluative Sciences.
3. Conceptual Underpinning – The Senior Friendly Hospital Framework

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

To help hospitals take a systematic, evidence-based approach, the RGPs of Ontario have developed a Senior Friendly Hospital Framework, with five domains designed to improve outcomes, reduce inappropriate resource use, and improve client and family satisfaction:

1) **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.

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

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

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

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

This Senior Friendly Hospital Framework provides a common pathway to engineer positive change in any hospital, and has been adapted in the current process to the unique context of the Central East LHIN. While all five components of the Senior Friendly Hospital Framework are required for optimal outcomes, it is recognized that implementing some of the framework’s elements – major updates to the physical environment, for instance – is a long-term undertaking, and that a staged approach to change is more feasible and practical in its implementation.
4. RGP Background Document and Self-assessment Process

The first step in the Senior Friendly Hospital Strategy is to gain an understanding of the current state of senior friendly hospital care in the Central East LHIN. The nine hospital organizations in the LHIN completed a self-assessment that facilitated reflection on structures and practices as they pertain to the RGP Senior Friendly Hospital Framework. With questions based on the framework, the Self-assessment Template gauged each organization’s explicit level of commitment, its efforts to date, its perceived challenges, and its specific needs in order to become a senior friendly hospital. Mapping senior friendly hospital efforts proved to be a valuable first step in identifying promising practices across the LHIN, as well as some of the challenges and opportunities for improvement in providing optimal care to older adults.

5. Goals of the Self-assessment Summary

The self-assessment summary report aims to:

- Review the current state of senior friendly hospital care in the Central East LHIN
- Acknowledge innovative practices in senior friendly hospital care
- Identify hospital and system-level improvement opportunities
- Promote knowledge sharing of innovative practices

6. Methods

In January 2010, the background document Senior Friendly Care in Toronto Central LHIN Hospitals and the Self-assessment Template – both structured upon the RGP’s Senior Friendly Hospital Framework – were delivered to the Chief Executive Officers of the nine hospital organizations in the Central East LHIN (Figure 2). The hospital organizations were supported in completing the self-assessments with a Frequently Asked Questions (FAQ) document prepared by the RGP of Toronto, along with three teleconference sessions held across the province to provide question and answer support. The teleconference sessions also provided a means for hospitals to provide direct verbal feedback on data collection processes. In March 2011, the completed self-assessments were submitted to the CE LHIN and were subsequently forwarded to the RGP of Toronto for analysis.

Each self-assessment was read and analyzed by a data support consultant and two independent clinical reviewers from the RGP of Toronto. Quantitative data was aggregated and sorted by the data support consultant using Microsoft Excel 2007. Analysis and interpretation of the quantitative and qualitative data were performed by the clinical review team. QSR NVivo 9 qualitative data analysis software was used in applicable cases. Self-assessment submissions were examined by each reviewer independently, with regular discussion to reach consensus over the results.

Hospital responses were examined for common themes and innovative practices and, where appropriate, aggregated to provide a system-based view. Like the self-assessment template, the
analysis was shaped around the Senior Friendly Hospital Framework, which provided a structured basis for the identification of common areas of focus, strengths, and opportunities for improvement.

In addition to the system-level promising practices and opportunities for improvement that this report highlights, each hospital organization received an individualized feedback letter. This letter included a summary of the hospital’s responses and the aggregate responses of the CE LHIN hospitals. The feedback also highlighted the hospital’s innovative practices and opportunities for improvement in providing Senior Friendly Hospital Care in the Central East LHIN.

Figure 2. Hospital Organizations in the Central East LHIN

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Inpatient Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute Care</td>
</tr>
<tr>
<td>Campbellford Memorial Hospital</td>
<td>✓</td>
</tr>
<tr>
<td>Haliburton Highlands Health Services</td>
<td>✓</td>
</tr>
<tr>
<td>Haliburton Site</td>
<td></td>
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<tr>
<td>Minden Site</td>
<td></td>
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<tr>
<td>(ED only)</td>
<td></td>
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<tr>
<td>Lakeridge Health</td>
<td>✓</td>
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<tr>
<td>Bowmanville Site</td>
<td></td>
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<tr>
<td>Oshawa Site</td>
<td></td>
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<tr>
<td>Port Perry Site</td>
<td></td>
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<tr>
<td>Whitby Site</td>
<td></td>
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<tr>
<td>Northumberland Hills Hospital</td>
<td>✓</td>
</tr>
<tr>
<td>Ontario Shores Centre for Mental Health Sciences</td>
<td></td>
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<tr>
<td>Peterborough Regional Health Centre</td>
<td>✓</td>
</tr>
<tr>
<td>Ross Memorial Hospital</td>
<td>✓</td>
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<tr>
<td>Rouge Valley Health System</td>
<td>✓</td>
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<tr>
<td>Ajax Pickering Site</td>
<td></td>
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<tr>
<td>Centenary Site</td>
<td></td>
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<tr>
<td>The Scarborough Hospital</td>
<td>✓</td>
</tr>
<tr>
<td>General Site</td>
<td></td>
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<tr>
<td>Birchmount Site</td>
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</table>

Hospital Organizations in the Central East LHIN: Nine hospital organizations participated in the Central East LHIN Senior Friendly Hospital self-assessment analysis. A summary of their sites and inpatient service categories is provided above.

7. Limitations of the Analysis

It is important to acknowledge the limitations of the current analysis of senior friendly hospital care in the CE LHIN. Hospital organizations varied in their resources, data collecting infrastructure, reporting methodology, and ultimately in the ease with which they were able to retrieve and report the data requested in the self-assessment. This resulted in variations in the quality and consistency of information, particularly the numerical data that was returned for analysis. Self assessment methodology has proven to be helpful in determining training, self-improvement, and coaching
needs. However, as with all data collection, care must be taken to ensure that information is accurate and credible. The exploratory nature of this report meant that both quantitative and qualitative data demanded a degree of subjective interpretation requiring clinical and contextual familiarity with the health system and the types of services discussed in the reports. Multiple clinical reviewers helped to minimize the effect of this limitation and consensus amongst the reviewers was reached without difficulty. Finally, the self-assessment template was not developed to perform a detailed environmental scan; therefore, this report is not intended to be a comprehensive comparison of all CE LHIN hospital services for seniors. For instance, in highlighting their successes, organizations may not have included all relevant activities, meaning that there are likely unreported services and activities worthy of mention.

8. Findings

8.1 ORGANIZATIONAL SUPPORT

There is widespread recognition as well as a growing commitment to senior friendly care by hospital organizations in the Central East LHIN. All facilities in the LHIN recognize the importance of developing strategies to improve care for seniors: eight of nine organizations articulate this specifically in their strategic plans, while the ninth organization has drafted goals for approval. In five hospitals, the board of directors has approved or is in process of reviewing comprehensive, facility-wide strategies that will move them toward becoming senior friendly organizations. This demonstrates a high level of organizational commitment toward senior friendly care across the LHIN, although designated committees tasked with advancing care for the elderly are present in only two organizations. While two other hospitals are in the process of forming senior friendly working groups, there may be an opportunity for more organizations to consider formal working structures to support the development of eldercare initiatives.

<table>
<thead>
<tr>
<th>Query</th>
<th>Hospitals with “Yes” Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your hospital organization have an explicit priority for senior friendly care in its strategic plan?</td>
<td>8 of 9 (1 in development)</td>
</tr>
<tr>
<td>Has the Board of Directors made an explicit commitment to become a senior friendly hospital organization?</td>
<td>4 of 9 (1 in development)</td>
</tr>
<tr>
<td>Has a senior executive been designated as the organizational lead for geriatric/care of the elderly initiatives?</td>
<td>7 of 9</td>
</tr>
<tr>
<td>Do you have a designated hospital committee for care of the elderly?</td>
<td>2 of 9 (2 in development)</td>
</tr>
</tbody>
</table>

The way that an organization supports and leverages its human resources can demonstrate its commitment to meeting the complex health care needs of an older adult population. One significant avenue of support is the provision of education to hospital staff on the clinical and service needs of older patients – this helps to nurture a facility-wide senior friendly culture. In over half of the CE LHIN’s hospitals, geriatrics education is already a component of, or is being incorporated into,
orientation procedures. Often, the content of this education is limited to key policies and clinical areas of risk, such as falls and restraint use. One organization goes further by providing geriatrics sensitivity training in the orientation of all staff – both clinical and non-clinical – as well as a more specific practice-based curriculum for nursing staff. Two other organizations describe plans to develop more widely offered geriatrics education in the orientation of clinical and non-clinical staff. Hospitals also facilitate the delivery of practical education to their staff by leveraging the skills of clinicians recognized as geriatrics champions. In one organization, professionals interested in gerontology form a group called the Geriatric Resource Program. They identify opportunities for unit-based education and act as informal opinion leaders – essentially becoming change agents to promote advances in bedside practice. In another organization, geriatrics champions lead team-based education modules to both clinical and non-clinical staff, in an initiative called “Building Bridges to Great Elder Care.” Clinical leaders are also involved in academic practices and work with their organizations and communities to build policies and standards. Older adults are patients and customers in virtually all units and services of the hospital, warranting educational initiatives that build core competencies in all hospital staff. The recognition that senior friendly practice and culture needs to be embodied throughout the entire organization, in clinical and non-clinical areas, is one that will advance an environment that is truly supportive of older adults.

The organizational support domain of the Senior Friendly Hospital Framework also examines formal structures for soliciting input from patients, families, and health system partners to guide the development of hospital programs and services. These efforts often go beyond generalized patient feedback mechanisms such as satisfaction surveys and patient relations processes. One example is the inclusion of community representation on durable hospital committees tasked with planning ongoing services. Four organizations describe community advisory committee structures, whose membership includes seniors and other patients reflecting the diversity of the populations they serve – one of these organizations has an advisory panel at each of its sites. Another facility describes a Joint Long Term Care Committee, used to plan services together with its health care partners. Other organizations reach out to their partners by attending various community-based groups and outreach activities. Hosting public forums and conducting focus groups, service-specific surveys, and opinion polls are other methods employed by CE LHIN hospitals to gain feedback from the community. One organization, located in a smaller community, commented that face-to-face conversations are feasible in its environment. Its CEO maintains high visibility and the organization itself has an open door policy with the public and media, strengthening its ability to build relationships with the people it serves. The needs of frail seniors are multi-dimensional and complex. Therefore, service planning that seeks broad and diverse input is best suited to guide the development of programs that meet the needs of older patients. Formal and comprehensive consultation with stakeholders and partners has the potential to improve integration and collaboration across the system as new services are developed and existing services are refined. The potential to positively impact patient and family satisfaction by formally integrating community feedback should also be evaluated.
8.2 PROCESSES OF CARE

The *Self-assessment Template* listed a number of clinical areas known to pose potential risks for vulnerable hospitalized seniors. Hospitals were asked whether or not they have protocols and monitoring procedures in place for these key areas of assessment and practice. Analysis of the self-assessment submissions revealed that certain clinical issues have received more attention than others. In CE LHIN hospitals, falls, restraint use, and pain management are the clinical areas where protocols and monitoring are most frequently in place (Figure 4). Conversely, continence, hydration/nutrition, sleep management, elder abuse, and the management of dementia-related behaviours are clinical areas where protocols and monitoring are least frequent in practice (Figure 4).

![Diagram](Image)

**Figure 4.** Hospitals with Protocols and Monitoring Procedures in Place for Clinical Areas of Risk to Older Patients

**Organizational Support – Promising Practices in the Central East LHIN**

- **Support for education throughout the organization, building the capacity of its human resources to serve older adults and to foster a senior friendly organizational culture. Education is planned and coordinated to reach all staff, whether in clinical or non-clinical roles.**
- **Care planning committees with comprehensive representation, including community members and health system partners, to help guide the ongoing development of seniors health services**
This observation is consistent with a recent study of geriatric ‘quality indicators’ for hospital care.\textsuperscript{10} One of the results of this study revealed a significantly higher rate of compliance with quality indicators for general medical care when compared with those for geriatric-specific issues. While having a protocol or monitoring procedure is only one aspect of providing care, the observations in this self-assessment analysis may identify potential care gaps for common geriatric issues arising in hospital. An innovative protocol that is being implemented in one organization and planned in others is the Hospital Elder Life Program (HELP), shown in studies to improve physical function and decrease the incidence of delirium in older hospitalized patients.\textsuperscript{11}

The self-assessment template also facilitated an examination of clinical metrics over three consecutive years for two indicators of care – fall rates and the acquisition of pressure ulcers. Eight of the nine CE LHIN hospital organizations have protocols designed to manage falls, and five utilize clinical protocols to manage pressure ulcers. Trending suggested reductions in pressure ulcer rates in several organizations, while the data for falls showed no significant improvement in the majority of sites. It will be important to examine the factors for success in organizations and/or sites that are able to measure improvement in these clinical areas. Whether they reflect positive features in care processes, systems or protocols, environment, leadership support, human resources, organizational culture, or any other variable, the disseminating the knowledge to that other organizations may benefit the hospital system as a whole.

A further observation was made about the data collection practices in the reporting of falls and acquired pressure ulcers. The range of the reported data, for pressure ulcers in particular, demonstrated a significant degree of variation. These variations may be affected by environmental and demographic differences between organizations, or by differences in technical definitions, monitoring, data collection, and reporting methods employed by each organization. Verbal feedback provided by hospitals during provincial teleconference support sessions confirmed that organizations employ different definitions and procedures in the collection of this data. In order for clinical metrics to provide meaningful data for any particular area of clinical performance, consistent definitions, methods, and reporting standards will need to be established. Once the identification of clinical priorities and suitable metrics are determined, there will be work ahead for hospitals to refine and to ensure compliance with successful clinical protocols so that improved outcomes in hospital care can be realized.


The self-assessment also inquired about senior friendly practices in the emergency department (ED). Access to professionals who provide specialized expertise is an invaluable resource in the ED – these include physiotherapists to support mobility and mental health crisis nurses. In CE LHIN hospitals, a key strategy is the prevention of avoidable hospital admissions by prompt identification of patients with geriatric health issues and referral to an appropriate service. In many organizations, Geriatric Emergency Management (GEM) nurses play a key role in this strategy, while social workers, CCAC case managers, discharge planners, or a specialized triage nurse also share this role. Early risk identification can help prevent unnecessary hospital admissions by facilitating the provision of appropriate community services that will support the patient at home. One organization describes collaboration with a seniors nurse from an on-site Family Health Team to provide assistance with these services. Another significant partnership in the CE LHIN is the Geriatric Assessment and Intervention Network (GAIN) – outpatient clinics based at four of the LHIN’s hospital organizations that provide comprehensive, inter-professional geriatric assessment and intervention. GAIN clinics accept high risk seniors referred from EDs – as well as inpatient units and primary care – and help find ways for non-acute patients to be managed in the community with support. When acute care services are appropriate for a patient, GAIN clinics arrange for the patient to be admitted to a
partnered Acute Care for Elders (ACE) unit within a hospital, thus facilitating direct transition to a hospital environment specially configured to meet the needs of the frail elderly.

Supportive transitions and discharge planning are key features of senior friendly hospital care and for this reason, hospitals were asked to report on their practices in these areas. Predictive discharge systems, such as checklists and screening tools, are used to quickly identify patients at risk of discharge delay. These mechanisms can help trigger early intervention by inter-professional team members and promote regular communication – through bedside whiteboards, for instance – with patients and families. The transfer of information during hospital transitions is also an important component in safe discharge processes. One organization is piloting the use of discharge packages – folders given to patients on admission in which relevant information pertaining to their hospitalization, including discharge summaries, is compiled. This integrates with an initiative called Better Outcomes for Older Adults through Safe Transitions (BOOST), which provides patient education, follow-up, and communication with family physicians. Similarly, another organization describes an effort called Assisting People Entering Nursing Home (ASPEN), and works in partnership with local LTC facilities to ensure the successful transfer of information. Support for patients prior to their actual transition home is engineered in a number of ways. One organization provides passes for “trial” discharges, in some cases supported by an occupational therapist performing home safety assessments. Where available, organizations employ their own post-acute care services – such as an inpatient rehabilitation unit, a Geriatric Assessment and Treatment Unit (GATU), a functional enhancement unit, and a transitional restorative care program – to maximize patients’ functional status for return home. Partnerships are very often utilized to support hospital transitions in the CE LHIN. For instance, hospitals work with the CCAC and community care in the Home First and Home at Last programs. These programs – currently in place in a number of organizations and being implemented in others – help link patients with additional support to return home to stay or to await a next level of appropriate care. Partnerships with post-acute care facilities offering rehabilitation and mental health care are also employed, along with the outpatient services such as the GAIN clinics already mentioned. Organizations also collaborate with the NPSTAT program, which provides specialized nursing expertise to partnered LTC facilities. Another facility works together with an on-site Family Health Team whose Seniors Nurse attends hospital rounds and family conferences and provides follow-up care to older patients at home. Collaboration and partnership within the hospital and reaching outward to the community are key variables that ultimately facilitate successful patient transition strategies. Fostering skills in inter-professional care and inter-organizational collaboration will strengthen these types of creative relationships and ultimately improve health system integration in order to help discharged seniors remain at home.
8.3 EMOTIONAL AND BEHAVIOURAL ENVIRONMENT

The emotional and behavioural environment of a hospital generates the atmosphere in which care and service are delivered, and this domain of the Senior Friendly Hospital Framework examines efforts in patient- and family-centredness, communication, diversity, satisfaction, and respect. In six CE LHIN organizations, education programs on geriatric issues are already or are in the process of being incorporated into staff orientation. While many of these programs focus on clinical issues and are provided to selected groups of staff, three hospitals describe programs in place or under development that furnish all staff – including those in clinical and non-clinical roles – with education on the needs of seniors. In one hospital, it is evident that organization-wide education efforts have an impact on teamwork, as non-clinical employees such as maintenance staff, porters, and housekeeping, are trained to recognize and respond appropriately to risky situations that may result in patient falls.

In order to solicit and engage patients and their families in care planning, CE LHIN organizations report generalized practices such as patient/family care conferences. In a small number of specialized services, this is done early in patients’ admission to promote communication and prompt recognition of their specific needs and wishes. One organization reports using whiteboards at the bedside to assist in communication, while another uses discharge folders in which patients collect information related to their admission. The BOOST program of one hospital, already mentioned in the Processes of Care section above, describes dedicated efforts to educate patients on their hospitalization and on the plan of care needed to help them transition back to the community. Satisfaction surveys are conducted on specific geriatric-focused units in order to solicit feedback relevant to this patient population, and two organizations also report patient/family councils within specific services that meet regularly to generate feedback and discussion.
In CE LHIN hospitals, programs to promote diversity services consist largely of measures to manage communication needs and spiritual support. To provide translation services, at least one facility employs full-time interpreters, while others maintain lists of staff members who speak different languages. One organization utilizes interpretation phone lines equipped with volume control, as well as picture communication cards to help those with linguistic, cognitive, and hearing difficulties. A small number of facilities provide programs for spiritual support by offering non-denominational religious services and links to community supports for different cultural and spiritual beliefs. To provide more comprehensive programming, one organization has formed a Cultural Competence Task Force to evaluate the language, religious, dietary and clinical needs of its patient populations.

8.4 ETHICS IN CLINICAL CARE AND RESEARCH

As highlighted in the background document, complex ethical issues frequently arise when caring for older patients. It is important for hospitals to have structures in place that support practitioners in approaching these challenges thoughtfully. Six CE LHIN hospitals have access to an ethicist for guidance in challenging situations. Another organization identifies this as a priority, while the two remaining organizations utilize an ethics committee and an inter-professional ethics consultation service to provide expertise into these clinical matters. Unique issues of high complexity were reported in mental health practice, while other services reported similar types of ethical situations related to the care of older adults, the most common of which are listed below:

- Palliative care/end of life issues
- Substitute decision maker issues
- Consent and capacity
- Decision making around discharge planning
- Withdrawing/withholding treatment
- Advance care plans
- Elder abuse

Central East LHIN organizations also have procedures in place to observe advance care directives. Six hospitals report specific policies – although in half of these cases, the scope is mostly limited to
guiding resuscitation decisions. Two organizations outline more detailed algorithms triggered early in admission, whereby patients are informed and supported in advance care planning, living wills, and power of attorney decisions. With respect to challenges that arise in capacity and decision making, CE LHIN hospitals describe a multi-level team approach. Appropriate members of the clinical inter-professional team first work with patients and caregivers to identify challenges and find resolutions. When it becomes necessary, internal resources such as ethicists, psychogeriatric services, risk departments, patient relations, and management are asked to provide assistance. One organization compiles web-based capacity evaluation tools for clinical staff and has developed a Capacity Improvement Team that conducts capacity assessments. Another hospital outlines a Clinical Ethics Decision Making Framework in which all clinical staff members are trained. When further intervention is required, external agencies such as the office of the Public Guardian and Trustee or the Consent and Capacity Board are consulted. With these resources and procedures in place, organizations need to ensure that all clinical staff members receive relevant and appropriate education on ethical issues, so that they know how to leverage these resources and manage unique ethical situations as they arise in practice. This is being done in the Central East LHIN through web-based resources, pamphlet information, and education sessions.

<table>
<thead>
<tr>
<th>Ethics in Clinical Care and Research – Promising Practices in the Central East LHIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>The availability of a clinical ethicist, and regular learning opportunities so that staff are prepared to respond to unique ethical challenges when they arise in practice</em></td>
</tr>
<tr>
<td><em>Formal structures to evaluate and advise on patient capacity</em></td>
</tr>
</tbody>
</table>

### 8.5 PHYSICAL ENVIRONMENT

When asked to identify barriers to senior friendly care, nearly all CE LHIN organizations cited aspects of their physical environments. Older hospital structures were built at a time when the majority of patients were younger and when building guidelines did not emphasize universal access. Many CE LHIN hospitals currently rely on building code requirements and on Accessibility for Ontarians with Disabilities Act (AODA) legislation when auditing and developing their physical spaces. There is a significant body of information regarding senior friendly environmental design and these principles go beyond generalized guidelines for disability and accessibility. For instance, some organizations are going beyond building code and accessibility guidelines by integrating colour coding and wayfinding features, providing hearing amplifiers, and installing ceiling lifts in patient rooms. A well implemented senior friendly physical environment incorporates building features that maximize safety and comfort, and engineers work design efficiencies to improve the ability of staff to monitor and interact with patients. In planning retrofit projects or site redevelopment, the design and

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implementation of senior friendly physical features can improve patient safety, comfort, and independence, while boosting staff satisfaction and direct patient care time. The implementation of a comprehensive senior friendly physical design in a hospital organization in Victoria, British Columbia suggests that this can be a cost-neutral undertaking when appropriate clinical knowledge guides design decisions. Three CE LHIN organizations have conducted audits of their physical spaces utilizing senior friendly resources, and one is in the planning stages. In one organization, this has helped define a project charter for physical improvements and in another, audit results were collated to identify opportunities for capital improvement requests. In third case, a completed senior friendly physical audit involved the participation of clinical personnel, and resulted in the implementation of design and equipment features such as senior friendly colour schemes, noise-reducing acoustic tiles, and ergonomic furniture. This organization also invites members of the public as well as county and town representatives to participate in its accessibility reviews, so that input from the community will be incorporated into the resulting recommendations. Capital improvement projects and significant infrastructure renewals are ongoing, long-term, and costly processes. Recognizing this, it is important that staff involved in these projects have training and access to resources on senior friendly environmental design so that the cumulative effect of physical upgrades is a senior friendly physical environment. There is an opportunity for organizations to consider more comprehensive training and knowledge acquisition in senior friendly environmental design for staff involved in the development, maintenance, and purchasing operations of the physical plant.

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**Physical Environment – Promising Practices in the Central East LHIN**

- Audits of physical spaces using senior friendly resources and involving clinical staff, leading to the implementation of design and equipment features that promote the safety, comfort, and function of frail seniors
- Including community members on accessibility committees to incorporate their feedback into future building upgrades
- The use of evidence-based senior friendly design resources in future capital planning and infrastructure renewal, redevelopment, and maintenance

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14 Vancouver Island Health Authority, Personal Communication
9. Looking Ahead – Moving toward Senior Friendly Hospital Care in the Central East LHIN

The Senior Friendly Hospital self-assessments and the ensuing analysis of submissions provide a summary of the current state of senior friendly hospital care in the Central East LHIN. This process has helped to identify key enablers that will facilitate continuous improvement in the LHIN and across the broader health care system.

The nine hospital organizations in the Central East LHIN demonstrate a growing commitment to senior friendly care. All have adopted, or are in the process of developing, goals pertaining to geriatric care in their strategic plans. Seven hospitals have also demonstrated their commitment by Designating a senior executive lead to guide the development of geriatric care initiatives. At the moment, two organizations have created formal committees to guide eldercare initiatives, while two more are in the process of doing so. Four organizations in total report the use of durable Community Advisory Committees to solicit input from community members. With these structures in place, there is an opportunity to incorporate community feedback — from members of the public representing patients and families, and from health system partners — into hospital working groups guiding the development of services for older adults. This may enable better service integration across the health system and, ultimately, better health outcomes for frail seniors who frequently need to access health services from multiple sectors.

Organizations also express support for education to strengthen and support the capabilities of their human resources. At least three organizations currently offer or describe plans to integrate geriatric learning principles in the orientation of all staff, including employees in clinical and non-clinical roles. This helps to empower teamwork and shared responsibility in looking after the needs of seniors, and fosters an organizational culture that is sensitive to older adults. Additionally, clinical staff members are often supported by experienced peers who act as informal opinion leaders, or geriatric champions. One organization describes a Geriatric Resource Program, where field-level champions identify emergent learning opportunities for other team members, and facilitate positive practice change on hospital units. The complex health care needs of seniors can best be met when inter-professional practice and teamwork are encouraged, and their application in daily care is part of the organizational and practice culture of a senior friendly hospital.

Most organizations are familiar with published best practice guidelines. For instance, the majority of CE LHIN hospitals have protocols in place for falls — an area of practice for which there are well developed evidence-based guidelines. The self assessment report also identified a number of clinical areas with less thorough adoption of protocols and best practice. Further opportunities exist to hone clinical practice in the areas of continence, hydration/nutrition, sleep management, elder abuse, and the management of dementia-related behaviours. Two well studied models of hospital practice, for
which positive outcomes have been reported, are the Hospital Elder Life Program (HELP)\(^{15}\) and the Acute Care for Elders (ACE) unit.\(^{16}\) A key variable measured in both of these models is the degree to which functional decline of patients is prevented as a result of the intervention. Functional decline can directly impact the ability of frail patients to return home, which has a secondary but far-reaching effect on the health system, evident in emergency room congestion and ALC rates. Given the level of impact on the patient and the health system, it is worthwhile to consider the implementation of clinical programs focused on the prevention of functional decline and evaluate their impact on patient outcome and satisfaction. One organization in the CE LHIN has implemented the HELP program, and two others are in the planning stages. In addition, several organizations have concrete goals to implement early mobilization protocols. As improved outcomes are realized, it will be worthwhile to consider broader implementation of these programs and protocols across the LHIN.

The Acute Care for Elders (ACE) model is also being implemented in the CE LHIN, in conjunction with another key service, the Geriatric Assessment and Intervention Network (GAIN). These clinics are being established in four CE LHIN hospital organizations, and are staffed with inter-professional teams that provide comprehensive geriatric assessment. They provide support, follow-up, and build linkages to the community for patients in need of services to help them remain at home. By linking directly with hospital emergency departments and with ACE units where appropriate, GAIN clinics provide an important interface to transition frail elderly patients into services that best suit their needs, while at the same time preventing unnecessary hospital admissions. The coordinated implementation across multiple sites in the LHIN is a positive example of system-wide planning of services for seniors. It will be important to continue evaluating key outcomes and the capacity of this continuum of services in the CE LHIN, so that successful components can be modeled and adopted elsewhere.

Organizations in the Central East LHIN identified practices that address diversity, patient-centred care, safety, medical ethics, and physical accessibility. These foundational principles have been present in hospitals for many years, often implemented in response to accreditation standards and, in the case of accessibility, through disability legislation. These generalized guidelines, however, do not often go far enough to fully meet the needs of frail seniors. In one organization, satisfaction surveys are conducted on specific geriatric-focused units in order to solicit feedback relevant to this patient population. Their outcomes may help inform decisions on quality improvement initiatives that will better account for the specific needs of seniors. The use of senior friendly design resources in physical infrastructure planning and development is another opportunity to address the needs of vulnerable seniors. These design principles incorporate measures that account for vision, communication, cognition, and dexterity impairments. When senior friendly principles are applied to


some of the hospitals’ ongoing core activities in health equity, patient- and family-centred care, patient safety, medical ethics, and physical accessibility, care for seniors and other vulnerable populations will be enhanced.

One way to measure improvement in the quality of care for seniors will be to establish clinically relevant senior friendly indicators. The issues in geriatric care require complex interventions; it will therefore be necessary to define meaningful indicators that all organizations can collect. The analysis of falls and pressure ulcer rates that was facilitated in this report illustrates this challenge. The range of data displayed a degree of variability between organizations which limited the utility of system-level analysis. In developing indicators, it will be necessary to standardize definitions and reporting methods so that meaningful outcomes can be measured and evaluated across the hospital system. This will become ever more significant in the next steps of the Ontario Senior Friendly Hospital Strategy. A province-wide summary 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 improvement in senior friendly hospital care to be adopted by the province or by clusters of LHINs. In this evolving work, it will also be important to consider alignment with indicators associated with overarching quality agendas such as the Excellent Care for All Act, the Canadian Patient Safety Institute (CPSI), and accreditation processes.

The recognition of early and successful adopters of senior friendly care among organizations within the LHIN and eventually across the province can serve as a catalyst for innovation and knowledge exchange. Providing a convenient forum for this knowledge exchange will encourage and enable all organizations across the system to hone their policies and practices. This could include a web-based toolkit that has the facility for expansion and interaction, and periodic knowledge exchange workshops with local and international experts. Working as a ‘system of innovation’ by facilitating opportunities for fruitful dialogue will serve to strengthen the senior friendly practice of all hospitals across the province.

Organizations in the Central East LHIN cited limited financial resources as a barrier to the broad execution of senior friendly activities. A commitment to allocate resources to implement programs that enhance organizational culture, operationalize evidence-based protocols, and improve physical spaces is an investment that will realize improved patient safety and staff productivity. The ongoing challenge is for organizations to find cost-effective solutions to progress toward a senior friendly state. Working toward the physical environment component of a senior friendly hospital, for example, is an area where enhanced knowledge acquisition can realize cost efficiencies. By referencing senior friendly design resources, new capital, building, and renovation expenditures can move an organization toward a senior friendly physical environment over time by ensuring that regular procurement and design decisions consider the needs of seniors. The case for “spending well” rather than “spending more” is well justified when the return on investment is the creation of a physical hospital environment that not only accommodates the needs of seniors, but also supports patients and visitors of all ages and disability levels. Knowledge sharing between organizations will
be another important process in continuing to empower the adoption of successful practices. Innovative and cost-effective delivery of system-wide, frailty-focused education adds enduring value by breaking down attitude and culture barriers, whilst improving the tools and skills of the hospital workforce to better serve frail seniors. Additionally, improved inter-professional collaboration and greater confidence in building effective cross-sector partnerships will foster innovation and may even reveal unexpected efficiencies in the health system. It is recognized that resources vary from organization to organization and that changes in accountabilities relating to senior friendly care may need to be phased in over a practical timeframe. These changes, however, will improve the quality of care and health outcomes, and also lower costs for hospitals and the health system by reducing errors and adverse events, with the potential co-occurring benefit of lowering wait times and ALC days.

An additional benefit of system-level collaboration in the context of senior friendly care is that system-level efforts can more readily focus on expanding partnerships with health quality and advocacy organizations or other regulatory groups, creating synergies that drive quality of care. Building code or accessibility regulations are examples of areas where enhanced guidelines on the needs of frail seniors may be of considerable utility, as seniors are clients in organizations throughout the community, not just in hospitals. As the hospital system becomes more robust in its senior friendly processes, its role within the entire health care continuum – and within our communities in general – should be examined.

The successful flow of patients through the health system, particularly of vulnerable seniors, depends on practices that promote high quality care in every health care setting, along with fluid transitions that enable health system integration. The Senior Friendly Hospital Framework is a lens through which organizations can examine system pressures; its principles promote a culture of high-quality, person-centred care. Through its culture, its practice, and its collaboration, the senior friendly hospital will work as a partner in the health care system to allow older adults to maintain their function as best as possible and to age at home with independence, dignity, and respect.
10. Highlights of Innovative Practices across the Central East LHIN

ORGANIZATIONAL SUPPORT

Support for Education to Foster a Senior Friendly Organizational Culture

- Annual Geriatrics Conference, “Bridging the Gap in Geriatric Care” (Lakeridge Health)
- Building Bridges to Great Elder Care (The Scarborough Hospital) – team-based education modules that include clinical and non-clinical staff
- Geriatric Sensitivity Training Provided in General Orientation for all Staff (Lakeridge Health) – clinical and non-clinical staff are included in this program
- Geriatric Resource Program (Lakeridge Health) – a program of informal mentorship by unit-based geriatric champions to support ongoing learning and practice change

Collaborative Service Planning Committees

- Community Advisory Committees (Haliburton Highlands Health Services, Lakeridge Health, Rouge Valley Health System, The Scarborough Hospital) – committees that solicit public feedback in the development and improvement of hospital services
- Joint Long Term Care Committee (Ross Memorial Hospital) – joint planning of services with partnered LTC facilities

PROCESSES OF CARE

Specialized Services and Programs

- Geriatric Activation Program (GAP – The Scarborough Hospital) – early identification of those at risk of cognitive/functional decline triggers enhanced therapy services
- Geriatric Assessment and Intervention Network (GAIN – Lakeridge Health, Peterborough Regional Health Centre, Rouge Valley Health System, Scarborough Hospital) – outpatient clinics offering inter-professional comprehensive geriatric assessment that link directly with emergency departments and hospital Acute Care for Elders (ACE) units
- Geriatric Engagement and Reintegration (GERI) Acute Service (Ross Memorial Hospital) – screens older patients at risk for complications and triggers early intervention
- Hospital Elder Life Program (Northumberland Hills Hospital, Peterborough Regional Health Centre) – leverages volunteers to engage older inpatients with the aim of reducing delirium and functional decline in hospital
- Personal Support Workers (PSWs) to Support Patients with Dementia/Delirium (Lakeridge Health) – PSWs are trained in de-escalation and diversion strategies to support this patient population
- Post-Acute Care – Transitional Restorative Care Program (TRCP – Rouge Valley Health System) – an inter-professional team provides restoration and reactivation activities using individual and group sessions to maximize utilization of therapeutic time
- Volunteers Assisting the Leisure Unique needs of our Elderly (VALUE – The Scarborough Hospital) – leveraging volunteers to support and interact with older patients (currently in development)

Clinical Care Protocols and Pathways

- Blaylock Discharge Risk Screening Tool (Northumberland Hills Hospital) – a tool used early on admission to facilitate early intervention by the inter-professional team
- Discharge Planning Trial Passes (Campbellford Memorial Hospital) – trial passes for 48 hours, and
for Occupational Therapy home assessments to support the transition home

- Fractured Hip Rapid Assessment and Treatment (FHRAT – Lakeridge Health, Northumberland Hills Hospital, Ross Memorial Hospital, Rouge Valley Health System) – a rehabilitation approach that is inclusive of patients with cognitive impairment
- Mobility of Patients Prior to Receiving Food Tray (Lakeridge Health) – finding frequent mobility opportunities helps reduce functional decline in hospital

Creative Partnerships to Improve Health System Integration

- Assisting People Entering Nursing Home (ASPEN – Ross Memorial Hospital and LTC Homes) – partnerships with local LTC facilities to facilitate transfer of information and successful patient transitions
- Family Health Team Partnership (Haliburton Highlands Health Services) – a Seniors Nurse from a partnered Family Health Team assists in early discharge and community follow-up
- Nurse Practitioners Supporting Teams and Averting Transfers (NPSTAT – Northumberland Hills Hospital) – provides NP support to partnered LTC facilities, helping to avoid unnecessary hospital transfers

EMOTIONAL AND BEHAVIOURAL ENVIRONMENT

- Better Outcomes for Older Adults through Safe Transitions (BOOST – Lakeridge Health) – focuses on patient education, follow-up, and communication with family physicians to support patient transitions
- Cultural Competence Task Force (Ontario Shores Centre for Mental Health Sciences) – reviewing language, religious, dietary, and clinical needs of the patient population
- Day in the Life of Tool (Ontario Shores Centre for Mental Health Sciences) – includes patients’ stories and behavioural profile to best incorporate their strengths and needs in care planning
- Discharge Package (Lakeridge Health) – a folder is provided to patients on admission, in which they compile information related to their hospital visit, including discharge summaries
- Diversity Orientation (The Scarborough Hospital) – integrates content on the needs of seniors as a patient population

ETHICS IN CLINICAL CARE AND RESEARCH

- Capacity Improvement Team (Lakeridge Health) – performs capacity assessments
- Clinical Ethics Decision Making Framework (Ontario Shores Centre for Mental Health Sciences) – clinical staff are educated in this framework for the management of challenging ethical situations

PHYSICAL ENVIRONMENT

- Accessibility Advisory Committee (The Scarborough Hospital) – includes community representatives in accessibility planning
- Senior Friendly Hospital Environmental Audits (Northumberland Hills Hospital, Ross Memorial Hospital, The Scarborough Hospital) – in at least one case, clinical staff were included in this process
# Appendix 1: Self Assessment Aggregate Responses

<table>
<thead>
<tr>
<th>Self-Assessment Question</th>
<th>Aggregate Response (Percent of Hospitals Responding “Yes”)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1.</strong> Does your hospital have an explicit priority or goal for senior friendly care in its strategic plan?</td>
<td>89% (100% including those in progress)</td>
</tr>
<tr>
<td><strong>B3.</strong> Do you have clinical staff who are formally recognized as geriatric champions within your hospital?</td>
<td>78% (89% including those in progress)</td>
</tr>
<tr>
<td><strong>C1.1.</strong> Has the Board of Directors made an explicit commitment to become a Senior Friendly Hospital?</td>
<td>44% (56% including those in progress)</td>
</tr>
<tr>
<td><strong>C1.2.</strong> Has a senior executive been designated as the organizational lead for geriatric/care of the elderly initiatives?</td>
<td>78%</td>
</tr>
<tr>
<td><strong>C1.4.</strong> Do you have a designated hospital committee for care of the elderly?</td>
<td>22% (44% including those in progress)</td>
</tr>
<tr>
<td><strong>C1.5.</strong> Does your hospital monitor age-specific indicators of utilization and quality of care relevant to seniors at regular intervals?</td>
<td>89%</td>
</tr>
<tr>
<td><strong>C2.1.</strong> These are areas of confirmed risk for seniors. Does your organization have protocols and monitoring metrics for care to address the following issues?</td>
<td>53% penetration of protocols and metrics for listed clinical areas of risk</td>
</tr>
<tr>
<td><strong>C2.7.</strong> Does your hospital offer any specialized geriatric services for older patients?</td>
<td>78%</td>
</tr>
<tr>
<td><strong>C3.1.</strong> Do your staff orientation and education programs have defined learning objectives for senior care?</td>
<td>44% (56% including those in progress)</td>
</tr>
<tr>
<td><strong>C3.2.</strong> Are age-sensitive patient satisfaction measures incorporated into hospital quality management strategies?</td>
<td>33%</td>
</tr>
<tr>
<td><strong>C3.3.</strong> What formal programs and processes do you have in place to help older patients feel informed and involved about decisions affecting their care?</td>
<td>11% (78% including those with generalized programs for all ages)</td>
</tr>
<tr>
<td><strong>C3.4.</strong> What programs and processes do you have in place to support diversity among seniors and their families?</td>
<td>11% (67% including those with generalized programs for all ages)</td>
</tr>
<tr>
<td><strong>C3.5.</strong> What programs and processes do you have in place to support appropriate attitudes and behaviours of health professional students and residents toward older patients?</td>
<td>44% (67% including those with generalized programs for all ages)</td>
</tr>
<tr>
<td><strong>C4.1.</strong> Does your staff have access to an ethicist to advise on ethical issues related to care of older patients?</td>
<td>67%</td>
</tr>
<tr>
<td><strong>C4.2.</strong> Does your hospital have a specific policy on Advance Care Directives?</td>
<td>67% (78% including those in progress)</td>
</tr>
<tr>
<td><strong>C5.1.</strong> Has your hospital conducted any senior friendly environmental audits of physical space using peer-reviewed guidelines?</td>
<td>33% (44% including those in progress)</td>
</tr>
</tbody>
</table>
## Appendix 2: Suggested SFH Indicators by Central East LHIN Hospitals

<table>
<thead>
<tr>
<th>System Utility</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Reduce unnecessary time spent in acute care</td>
<td>● Pressure Ulcers: percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher)</td>
</tr>
<tr>
<td>● Reduce unnecessary hospital admissions</td>
<td>● Falls</td>
</tr>
<tr>
<td>● Readmission Rate by Age 65+ (could be broken down into 65-74, 75-84, and 85+ age groups)</td>
<td>○ Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days</td>
</tr>
<tr>
<td>● Appropriate transitions to post hospital services</td>
<td>○ Falls with fractures</td>
</tr>
<tr>
<td>● LOS Acute – age stratified</td>
<td>● Delirium</td>
</tr>
<tr>
<td>● LOS ED – age stratified</td>
<td>● Insertion of indwelling catheters with subsequent urinary tract infections</td>
</tr>
<tr>
<td>● ER wait times</td>
<td>● Loss of function and immobility</td>
</tr>
<tr>
<td>● ALC</td>
<td>● Dehydration</td>
</tr>
<tr>
<td>● The number of patients aged 75+ included in ER volume reports</td>
<td>● Constipation</td>
</tr>
<tr>
<td></td>
<td>● Polypharmacology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Satisfaction survey</td>
<td>● Medication reconciliation at transition points</td>
</tr>
<tr>
<td></td>
<td>● Functional independence</td>
</tr>
<tr>
<td></td>
<td>● FHRAT (Fractured Hip Rapid Assessment and Treatment)</td>
</tr>
<tr>
<td></td>
<td>○ The acute and rehab data from the FHRAT are age-specific (e.g. Under 60, 60-69, 90+)</td>
</tr>
<tr>
<td></td>
<td>○ Delay to hip fracture surgery measures include a focus on patients ≥65 or ≤105</td>
</tr>
<tr>
<td></td>
<td>● SFH domains</td>
</tr>
<tr>
<td></td>
<td>○ Environment – completion of environment checklist to identify opportunities for improvement</td>
</tr>
<tr>
<td></td>
<td>○ Continuity of Care – referral volumes to GAIN clinic and impact on ED wait times</td>
</tr>
<tr>
<td></td>
<td>○ Clinical expertise and practice – staff participation in education sessions to promote geriatric best practices</td>
</tr>
</tbody>
</table>

**Notes:**

- Implement ‘monitoring indicators’ until there is confidence in the applicability and reliability of chosen indicators that measure true impact on Senior Friendly Care.
- Prevention of delirium – demonstrated use of a protocol and, over time, demonstrated clinical changes with treatment. The most immediate goal would be to prevent delirium.
- Need to balance risk of falls with mobilization.