A Summary of Senior Friendly Care in North East LHIN Hospitals

Cal Martell (Martell Consulting), Martha Auchinleck (North East LHIN), Kim Rossi (North East Specialised Geriatric Services)

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Executive Summary

The Integrated Health Service Plan for the North East LHIN includes eight strategic directions intended to improve the health of all North East residents. Those related to Aging at Home, Alternate Level of Care, and Emergency Department wait times are particularly impacted by the capacity to provide care and support to older patients.

The North East ALC strategy, while recognizing the need for enhanced community capacity, has been forward thinking in identifying the potential to better align hospital practices and processes of care with the needs of older patients.

- Improved hospital performance related to seniors.
- Improved health system performance and integrated care pathways.

The IHSP is also aligned with provincial health system priorities to improve access to health services:

1) Reducing wait times in Emergency Departments;
2) Reducing the time people wait in Alternate Level of Care beds in Ontario’s hospitals; and
3) Supporting the roll out of Ontario’s Diabetes Strategy.

A Senior Friendly Hospital is one in which the environment, including the organizational culture, accommodates and responds to seniors’ physical and cognitive needs; promotes good health, is safe and involves and supports all seniors, their families and caregivers to be full participants in their care. The aim is to enable seniors to regain their health after their acute care is completed, so that they can transition to the next level of care that best meets their needs.

A Senior Friendly Hospital Strategy has been endorsed by the Ministry of Health and Long Term Care and the LHIN Council. The strategy, in applying an evidence-based framework to the development of age-appropriate hospital care, is strongly aligned with both provincial and regional strategic objectives and outcomes. The first phase, an analysis of Senior Friendly Care, is intended to promote awareness of senior friendly hospital care, provide a baseline of current activity, and identify promising practices intended to improve the health status of hospitalized seniors in Ontario.

Organisational Support: While hospitals demonstrated a strong commitment to enhance acute care of the elderly across the region, the commitment to a systematic, organisational response can best be characterized as emerging. Only 26% of hospitals report using age-specific indicators, focused primarily on nurse sensitive indicators and subject to mandatory reporting. Access to geriatric knowledge and expertise has been identified as a barrier to the further development of Senior Friendly hospital care. There is a need to further discuss and clarify how the Senior Friendly Hospital Framework can be adapted to the realities of rural northern hospitals.

Processes of Care: Hospitals in the North East have demonstrated a strong commitment to improve clinical care for older patients. Nonetheless, there are potential care gaps for common geriatric issues arising in hospital, such as de-conditioning and dementia related behaviours. A number of innovative,

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1 North East LHIN Integrated Health Services Plan, 2010-2013.
targeted discharge programs have been successfully implemented for older patients. However, there is a concern that access to home and community care in the rural north impacts the safety and sustainability of discharges for older patients. A need to refine reporting requirements associated with designated clinical protocols has been identified, in order to realise improved outcomes for hospital care of the elderly.

**Emotional Behavioural Environment:** Many hospitals in the North East LHIN promote a patient-centred philosophy of care. 22% reported having formal education programs in place to address senior friendly care on topics ranging from elder abuse to dementia. There is a rich and diverse range of programs in place to respond to the needs of Francophone seniors and elders in the North East. 70% of hospitals reported strategies to inform and involve older patients and their families in decisions about their care. Some have developed senior-focused mechanisms such as advisory councils. Limited access to geriatric knowledge and expertise has been identified as a constraint on the extent to which training and education regarding the needs of older patients can be delivered across the North East LHIN.

**Ethics in Clinical Care and Research:** Complex issues arise daily when caring for older adults. Overall, there is a consistency in the understanding and approach of hospitals to ethical issues in care of the elderly. A majority of hospitals in the North East have specific policies on Advance Care Directives. Although a minority report being able to access an ethicist for consultation, some report this role is ably performed by physicians in small community hospitals with a close knowledge of the patient and their perspectives.

**Physical Environment:** The physical environment is identified as a barrier to senior friendly hospital care in the North East. Hospitals have planned significant design improvements through ongoing renovations undertaken within the limits of existing resources. These include improvements to way finding, flooring, and doorways which will enhance the safe mobilisation of older patients. There is an opportunity to integrate evidence-based Senior Friendly Design Guidelines into hospital capital planning...

**Looking Ahead:**

Despite some concern and uncertainty regarding the Senior Friendly Hospital Strategy, and its implications for small rural hospitals in the North East, 83% of hospitals reported the Self-Assessment was important in renewing the importance and awareness of senior friendly hospital care. More than 45 senior friendly initiatives were identified, reflecting an ambitious agenda for Senior Friendly Hospital Care for the North East over the next three years. Key themes for these improvements were to optimize senior friendly programs and services, promote an integrated continuum of care, senior friendly education and culture, designated clinical protocols, and improved physical environment.

The main outcomes which were cited for the proposed senior friendly care initiatives in the North East, in order of frequency of reporting, included:

- Improved the safety and quality of care;
- Improved patient flow and reduced ALC days;
- Improved ER wait times and utilisation;
- Implementation of Senior Friendly Strategies.

However, hospitals also recognise that their collective efforts will not realise system-wide outcomes in the absence of a supported system-wide strategy. The need for a regional approach to adapt the Senior
Friendly Hospital Framework to the unique needs of the rural north was suggested for the North East LHIN to consider. Standardised measurements and indicators, as well as equitable access to educational resources were also noted as important to promote change.
The North East LHIN Senior Friendly Hospital Strategy

Background:

The North East LHIN plans, funds, and coordinates the delivery of health services to almost more than 552,000 people, representing 4.5% of the population of Ontario living across 40% of the land mass of the province. The population 65 years or more is represents 16% of the overall population. Seniors are expected to represent 29.1% of the total population by 2031, or nearly one in every three persons.

The North East LHIN is home to a very diverse population, with almost 24% being Francophone and 10%, Aboriginal/First Nations /Métis.

There is an investment of more than $762M supporting 23 hospitals representing 66% of the regional health system budget of the North East LHIN.

While the health of North East residents is comparable in some respects to that of the average Ontarian, they are less likely to report being in very good or excellent health, have less access to medical doctors, and the region experiences a higher than average rate of ALC designation.

The Integrated Health Service Plan for the North East LHIN includes eight strategic directions intended to improve the health of North East:

- Aboriginal / First Nations / Métis Health Services
- Addiction and Mental Health Services
- Aging at Home
- Alternate Level of Care (ALC) Strategies and Solutions
- Diabetes Care
- Emergency Department Wait Times
- French Language Health Services - An Integrated Approach
- Health Human Resources
- Optimize Surgical Services

The IHSP is also aligned with provincial health system priorities to improve access to health services:

1) Reducing wait times in Emergency Departments;

2) Reducing the time people wait in Alternate Level of Care beds in Ontario’s hospitals; and

3) Supporting the roll out of Ontario’s Diabetes Strategy.

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3 North East LHIN Integrated Health Services Plan, 2010-2013.

A Summary of Senior Friendly Care in North East LHIN Hospitals
The Senior Friendly Hospital Strategy, in applying an evidence-based framework to the development of age-appropriate hospital care, is therefore strongly aligned with both provincial and regional strategic objectives and outcomes. Building upon formative work initiated in Champlain LHIN, the Senior Friendly Hospital Framework was first integrated into the planning of the Toronto Central LHIN in 2010, with support from the Regional Geriatric Program of Ontario. It has since been endorsed by the Ministry of Health and Long Term Care and the LHIN Council. The first phase, an analysis of Senior Friendly Care, is intended to promote awareness of senior friendly hospital care, provide a baseline of current activity, and identify promising practices intended to improve the health status of hospitalized seniors in Ontario.

**CONTEXT**

The proportion of the population 65 years of age or more in North East LHIN, at 16%, is slightly higher than the provincial average of 13.6%, and is likely to increase more rapidly than the rest of the province. It is estimated the population 65 years of age will increase from 90,985 to 162,260 by 2031, a 78% increase.

Seniors are the primary user of hospital services across the North East region. North East hospitals reported older patients used 70.7% of hospitals days and 71.6% of ALC days in 2009/10. Hospital performance and quality improvement therefore hinges heavily on a focused strategy to promote more age-appropriate acute care responding to the unique health needs of this patient population.

There are a number of interesting trends emerging from closer examination of this data. The overall utilisation in the proportion of hospital days over the three years from 2007-
10, has been relatively stable. However, the proportion of hospital days used by patient 85 years of age or more has moderately increased. Hospitals reported a slight decrease in the proportion of ALC days used by older patients during this same period, despite the increase in population aging. This information reinforces our understanding that patterns of hospital utilisation can, and have been influenced in the North East region.

Comparable to other jurisdictions, seniors’ utilisation of Emergency Room services was approximately 19.9% in 2010.
Comparing LHIN regions, the percent of acute care beds occupied by ALC patients is highest in the North East. The North East LHIN’s ALC strategy responds in part, to the needs of seniors at risk of cognitive and functional decline, hospitalisation and/or placement. A Balance of Care Study for North East LHIN concluded that 32% to 69% of persons waiting for long term care could have their met in community or supportive housing. The North East ALC strategy, while recognizing the need for enhanced community capacity, has been forward thinking in identifying the potential to also better align hospital practices and processes of care with the needs of older patients:

- Improved hospital performance related to seniors\(^5\).
- Improved health system performance and integrated care pathways.

The Senior Friendly Hospital Strategy is similarly focused on this patient population. It is intended to emphasize the multiple dimensions of organizational change essential to achieve improved health outcomes for seniors. The North East LHIN, through the provincial Senior Friendly Hospital Strategy, will support hospitals in adopting the Senior Friendly Hospital Framework and specifically, to align needs and resources to achieve the framework and to integrate measurable objectives into hospital service accountability agreements. Moreover, the Senior Friendly Hospital Strategy provides concrete opportunities for hospitals to achieve their commitments within the Excellent Care for All Act.

\(^5\) North East LHIN Integrated Health Services Plan, 2010-2013.
Conceptual Underpinning – The Senior Friendly Hospital Framework

**Hospitalisation as a Pivotal Event:**

While older patients clearly benefit from hospital treatments, the experience of hospitalisation presents risks for adverse events and functional loss which can have a significant impact on their post-discharge trajectory. The greater complexity of care needs of older adults increases the risk for preventable adverse outcomes, and complicates the transition out of hospital. In addition to the normal physiological changes of aging, older patients may have multiple co-morbidities and experience the complex interaction of chronic conditions. The patterns of relapse and recurrence in frail older patients creates a set of complex physical, social and functional consequences that are not well-served by the episodic focus of acute care.

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

It was in recognition of these risks that the Senior Friendly Hospital Framework was first developed in 2004 in collaboration with the Regional Geriatric Program of Eastern Ontario. To help hospitals take a systematic, evidence-based approach, a Senior Friendly Hospital Framework was developed, with five domains designed to improve outcomes, reduce inappropriate resource use, and improve client and family satisfaction.

The framework integrates evidence from both acute care of the elderly with that of knowledge translation, based heavily upon the Ottawa Model for Research Use.

It has subsequently been endorsed provincially by both the Regional Geriatric Programs of Ontario and more recently, the Ministry of Health and Long Term Care who, in partnership with the LHINs, have launched a provincial Senior Friendly Hospital Strategy. The Toronto Central LHIN was the first to develop and implement a LHIN-wide strategy, and has been charged with coordinating the provincial initiative on behalf of the LHIN Council.

The Senior Friendly Hospital Framework describes a comprehensive approach that is to be applied to organizational decision making. Recognizing the complexity of frailty, and the vulnerability of seniors to the unintended consequences of hospitalization that may

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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.

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

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

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

5) **Physical Environment** – *The hospital’s structures, spaces, equipment, and facilities provide an environment which 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 can be adapted to the unique context of the North East LHIN. While all five components of the Senior Friendly Hospital Framework are required for optimal outcomes, it is recognized that a staged approach to change may be more feasible and practical in its implementation.

In recognition of the unique role of rural hospitals in the North East LHIN, there is significant potential to adapt or tailor the implementation of the strategy to reflect their role in the delivery of a more integrated and coordinated continuum of care for older patients.
The fact that approximately 40% of the population in Northeastern Ontario lives in rural communities and they are served by 19 hospital organisations operating through 21 small hospitals, is an important context for health planning and serviced delivery. These hospitals, operating as a single point of access to the regional health system in their respective communities, function in coordination with four larger hub hospitals.

Given this unique and important role, consideration must be given to how the Senior Friendly Hospital strategy can be feasibly and effectively integrated into the structures and processes of small rural and northern hospitals in the North East.

**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 care in North East LHIN. Hospitals across North East LHIN completed a self-assessment on how senior friendly their hospital is. With questions structured around the Senior Friendly Hospital Framework, the *Self-assessment Template* gauged each organization’s level of commitment, their efforts to date, and their perceived challenges and needs in becoming a senior friendly hospital. This first step in mapping senior friendly hospital efforts proved valuable in identifying promising practices across the LHIN, as well as some of the challenges in providing optimal care and the opportunities for improvement.

Prior to completion of the Self-Assessment Template, each hospital was provided a copy of the *Background Document: Senior Friendly Care in Toronto Central LHIN Hospitals* to provide background on the concept and rationale for senior friendly acute care.

**Goals of the Self-assessment Summary**

The purpose in conducting the self-assessment is fourfold:

- To serve as a summary of the current state of senior friendly care in North East LHIN
- To acknowledge innovative practices in senior friendly care
- To identify hospital and system-level improvement opportunities
- To promote knowledge sharing of innovative practices

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9 Integrating Innovative Ideas: Small Rural Hospital Summit, North East LHIN, 2010.
Methods

In January 2011, the background document *Senior Friendly Care in Toronto Central LHIN Hospitals* along with the *Self-assessment Template*, both structured around the RGP’s Senior Friendly Hospital Framework, were delivered to the Chief Executive Officers of hospital organizations in the North 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, as well as a series of three teleconference sessions held across the province to provide question and answer support. These teleconference sessions also provided a means for hospitals to provide anecdotal feedback on the data collection processes. In April 2011, the completed self-assessments were submitted to the North East LHIN and were subsequently forwarded to the North East Specialised Geriatric Services for analysis.

**Figure 2: Hospital Services in the North East LHIN**

<table>
<thead>
<tr>
<th>Large Acute Care Hospitals*</th>
<th>Small Community-Acute Hospitals</th>
<th>Small Community-Mixed Hospitals</th>
<th>Complex Continuing Care Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Bay Regional Health Centre</td>
<td>Elliot Lake-St. Joseph’s General Hospital</td>
<td>Blind River District Health Centre</td>
<td>St. Joseph’s Continuing Care Centre (Sudbury)</td>
</tr>
<tr>
<td>Timmins &amp; District Hospital</td>
<td>Little Current – Manitoulin Health Centre</td>
<td>Chapleau Health Services</td>
<td></td>
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<tr>
<td>Sault Area Hospital</td>
<td>Mattawa General Hospital</td>
<td>Englehart and District Hospital</td>
<td></td>
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<tr>
<td>Sudbury Regional Hospital</td>
<td>New Liskeard – Temiskaming Hospital</td>
<td>Espanola General Hospital</td>
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<td></td>
<td></td>
<td>Hearst Notre Dame Hospital</td>
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**Organization of Hospital Services in North East LHIN Hospitals:** Twenty-five hospitals participated in the Senior Friendly Hospital Self-Assessment in North East LHIN.

*Large acute care hospitals >100 beds*

**Small community acute hospitals <100 beds primarily acute care.**

Small community-mixed hospitals offer a mix of acute, continuing and long-term care beds in their communities.
An independent reviewer read and compiled the results from each self-assessment in a comprehensive database to aid in the analyses. A preliminary analysis for each hospital was provided which was in turn reviewed by clinical and administrative leaders within North East Specialised Geriatric Services and the North East LHIN. Given the qualitative nature of some elements of the self-assessment, some degree of contextual familiarity of the services provided within each hospital was required. The joint review provided feedback regarding system-level initiatives and key enablers to help ensure the success of the Senior Friendly Hospital Strategy in meeting the physical, emotional and psychological needs of seniors in hospital.

The analysis, like the template, was structured upon the common elements of the Senior Friendly Hospital Framework in order to facilitate 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 received an individualized feedback letter. This letter included a summary of the hospital’s responses, the aggregate responses of hospitals in their sector, and the aggregate responses of all North East LHIN hospitals. The feedback also highlighted the hospital’s innovative practices and opportunities for improvement in providing Senior Friendly Hospital Care in North East LHIN.

**Limitations of the Analysis**

It is important to acknowledge the limitations of the current analysis of senior friendly hospital care in the North East 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 is most helpful in determining training, self-improvement, and coaching needs.

Finally, the self-assessment template was not developed to perform a detailed environmental scan and therefore, this report is not intended to be a comprehensive comparison of all NE LHIN hospital services for seniors. In highlighting their successes for instance, organizations may not have included all relevant activities, meaning that there are likely unreported services and activities that are worthy of mention.

Additionally, the varied knowledge and experience with the Senior Friendly Hospital Framework contributed to some variation in responses. Notwithstanding these limitations, the effort and commitment to participate in this phase of strategy development was obvious on the part of all hospital leadership teams, and provides a solid basis for future collaborative planning
Findings

Part 1: ORGANIZATIONAL SUPPORT

The Senior Friendly Hospital Framework as a concept had not been widely disseminated across the North East LHIN prior to its introduction to the LHIN Council. A number of participating hospitals expressed uncertainty how the framework could be adapted to the needs of small rural hospitals. Others expressed concern about the impact of a population-based strategy focused on seniors, on their over-arching orientation towards patient and family centred care for all the populations they served.

Nonetheless, participating hospitals in the North East demonstrated a broad ranging commitment to further develop senior friendly care, with 78% identifying 31 priorities to become Senior Friendly. A majority of priorities, perhaps reflective of the unique role of small rural hospitals as points of access to the health system, identified the need for both enhanced clinical care, as well as improved integration of seniors’ health services. However, a significant number of hospitals indicated a need to promote a culture and approach more reflective of the unique needs of older persons.

While hospitals demonstrated a strong commitment to enhance acute care of the elderly across the region, the commitment to a systematic, organisational response can best be characterized as emerging. Two of the participating hospitals have made an explicit commitment to become a Senior Friendly Hospital at the Board level. However, six have established relevant coordinating structures or processes, and 39% of hospitals have identified a senior executive lead for senior friendly care. This appears to reflect to at least some extent, a combination of the resource constraints experienced by smaller hospitals, as well as uncertainties about the feasibility of developing more focused strategies. Consequently, the need for more discussion of the Senior Friendly Hospital Framework at hospital leadership tables may

**Figure 3: North East Senior Friendly Care Priorities (A3)**

<table>
<thead>
<tr>
<th>Optimising Senior Friendly Care (15)</th>
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</thead>
<tbody>
<tr>
<td>Clinical protocols and metrics (8); develop specialised geriatric services and geriatrician services (3)GEM (2), restorative care; dementia; renal care, physiotherapy, chronic disease management,</td>
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<table>
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<th>Support an Integrated Seniors Health System (11)</th>
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<tbody>
<tr>
<td>enhanced access to community care (4); collaboration among services (3); LTC expansion (3) Supportive Housing; complex continuing care</td>
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<tr>
<th>Senior Friendly Environmental Design (6)</th>
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<table>
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<tr>
<th>Advance Senior Friendly Hospital Strategy (4)</th>
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<tr>
<td>Including age-friendly network, Gentle Persuasion education, conduct seniors survey</td>
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**Senior Friendly Care Initiatives and Priorities:** Hospitals were asked to describe their most successful Senior Friendly Care initiatives (c 2.4) and their top priorities (A3) for ongoing development. Responses clustered into the above themes.
be required. Several hospitals identify care of the elderly as their core business and not requiring a focused approach.

Despite the challenges faced by small rural hospitals, many are in unique positions to influence the delivery of more integrated and coordinated seniors’ health services. It was apparent in the review of their responses that there is significant potential to leverage other hosted services, from primary to continuing care, in order to develop expertise and clinical programs focused on the needs of older patients. Indeed, several hospitals have undertaken major commitments within their communities in this regard.

Access to geriatric knowledge and expertise has been identified by some, as an impediment to the development of senior friendly hospital care. Although 71.1 positions were identified by hospitals as dedicated to care of the elderly, many were associated with continuing and long term care hosted by small community hospitals with a mix of services. In terms of focused practice, only 1 geriatrician, 7 MDs and 4 Advance Practice nurses, 4.2 GEM nurses were identified across the 23 hospitals of the North East.

The manner in which hospitals engage and solicit input from older patients and their caregivers is also a significant factor in their responsiveness to this population. While many hospitals report using satisfaction surveys to solicit input, not all of these are structured by age cohort. However, the extent to which rural hospitals in particular involve seniors in governance and formal decision-making structures is significant. These represent important mechanisms through which hospitals establish and maintain responsiveness to the needs of older members of their communities.

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**Figure 4: North East Organizational Support Questions**

<table>
<thead>
<tr>
<th>Query</th>
<th>Hospitals with “Yes” Response</th>
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<tr>
<td>Does your hospital organization have an explicit priority for senior friendly care in its strategic plan? (A.3)</td>
<td>5/23</td>
</tr>
<tr>
<td>Has the Board of Directors made an explicit commitment to become a senior friendly hospital organization? (C1.1)</td>
<td>2/23</td>
</tr>
<tr>
<td>Has a senior executive been designated as the organizational lead for geriatric/care of the elderly initiatives? (C1.2)</td>
<td>9/23</td>
</tr>
<tr>
<td>Do you have a designated hospital committee for care of the elderly? (C1.4)</td>
<td>6/23</td>
</tr>
</tbody>
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**Figure 5: North East Organizational Support: Solicit Input from Seniors/Family Members (c 1.3)**

- Satisfaction Surveys (11)
- Patient Family Councils (5)
- Formal Community Consultation, incl. forums & focus groups (5)
- Governance (4): Board representation, Community Advisory of Senior Friendly Committees
- Community Advisory or Senior Friendly Committees (3)
It is also important to keep in mind that, while it may be important to have clear communication structures and processes in place for the organisation to learn from the experience of their patients, the relationship of many small community hospitals with their patients is unique. In a situation where community members are serving community members, there is a greater opportunity for direct individual dialogue.

While governance and decision-making structures have a significant impact in shaping a Senior Friendly culture, the adoption of age-sensitive indicators is pivotal to performance management. Although the scope and level of senior focused performance management is limited, 52% of hospitals (12) reported using some degree of age-specific indicators. The majority of these focused on age-sensitive incident and quality reporting, such as falls and pressure ulcers, which are identified as required organisational practices by Accreditation Canada and/or are subject to mandatory reporting requirements for complex continuing and long term care.

As noted previously the population of the North East is quite diverse, with 24% of the population being francophone, and 10% First Nations/Aboriginal/Métis. 78% of North East LHIN hospitals report having established organisational policies and practices reflective of the diversity of their communities. While these include interpretation and other services comparable to those of other hospitals in Ontario, a significant proportion of hospitals have adopted policies bilingual serviced delivery and traditional healing. The use of patient navigators and the inclusion of elders in health care planning are some of the mechanisms used by hospitals in the North East LHIN to respond to the cultural needs of aboriginal patients.
Summary Findings – Organisational Support

- 18 hospitals report a priority for becoming Senior Friendly, with the focus on optimising senior friendly care, supporting an integrated seniors’ health system, and environmental design, as well as advancing elements of a Senior Friendly Hospital Strategy.

- There is a need to further discuss and clarify how the Senior Friendly Hospital Framework can be adapted to the realities of rural northern hospitals.

- 70% of hospitals have formal processes for engaging seniors and family members in organisational planning and decision-making. This includes involvement in governance with representation of seniors /elders as members of the Board, and standing committees.

- While only 2 hospitals in the North East LHIN have made an explicit commitment to become a Senior Friendly Hospital at the Board level, 5 have identified it in their strategic plans and 6 have designated hospital-wide coordinating committees.

- 78% of hospitals reporting having policies and practices in place to reflect the diversity of their communities. More than half (57%) of these are oriented toward Aboriginal cultures and populations, and 39% towards Francophones.

- Only 26% of hospitals report using age-specific indicators, focused primarily on nurse sensitive indicators and subject to mandatory reporting. Several are beginning to look at utilisation by age cohort.

- Access to geriatric knowledge and expertise has been identified as a barrier to the further development of Senior Friendly hospital care.

Promising Practices: Organisational Support

- The establishment of an interdisciplinary Elder Care Committee to promote program development, as well as staff education and training.

- Bi-annual visits from an interdisciplinary geriatric team to provide consultation and education.

- Plan to establish Seniors’ Centre of Excellence to build geriatric capacity;

- The creation of a Seniors Health Advisory Committee to capture advice and input from seniors and the community at large.

- Recruitment of a physician specialised in care of the elderly as a resource for clinical leadership in senior friendly care.
Part 2: PROCESSES OF CARE

The Self-Assessment Template listed a number of known clinical areas of risk for hospitalized seniors, and asked hospitals whether they have active protocols and/or metrics in these key clinical areas. In the LTC and CCC sectors, there are mandatory reporting requirements for a number of clinical areas, including falls, incontinence, pressure ulcers, restraint use, pain, and behavioural problems. Analysis of the self-assessment submissions also highlighted that certain clinical issues have received more focus in the past compared to others. Traditional nurse sensitive indicators such as falls, pressure ulcers, restraint use, and adverse drug reactions are clinical areas that were most frequently given the attention of a clinical protocol and monitoring procedure. (Figure 8)

In fact, 78% of North East LHIN hospitals reported having protocols and active monitoring for both falls and pressure ulcers. Conversely, the prevention of deconditioning and dementia related behaviour management, which are major risks factors for being designated ALC, were reported less frequently as having an active protocol and monitoring procedure in place. This observation is consistent with a recent study of geriatric ‘quality indicators’ for hospital care\textsuperscript{10}. In the study, there was a significantly higher rate of compliance with quality indicators for general medical care versus geriatric-specific care indicators (e.g. delirium, dementia, and physical function). Overall across the North East, hospitals reported that clinical protocols and indicators have been adopted for only 42% of the risk factors associated with hospitalisation of the elderly. 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.

The Self-Assessment also requested hospitals review clinical indicators for the past three years for two areas of practice – fall risk prevention and hospital acquired pressure ulcers. These are to be measured through the rate of in-hospital falls/000 patient days, and the percentage of patients who acquired decubitus skin ulcers in the previous three years. 56% of hospitals were able to report fall rates and 65% for pressure ulcers.

In order for clinical metrics to provide data that will generate a meaningful system-level view, consistent definitions, methods, and units of expression will need to be established for any particular clinical area of focus. Once the identification of clinical priorities and indicators are established, 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.

**Figure 10: North East Most Successful Initiatives to improve clinical care (C 2.4)**

<table>
<thead>
<tr>
<th>Clinical Protocols and Indicators (22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall risk screening; Medication Reconciliation, Nutritional Wound pathway; Bowel management (2), pressure ulcer prevention; restraints; stroke protocol</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geriatric Program Development (11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restorative care model; Home First; GEM; HELP; GDH (GARD); Healthy aging program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Senior Friendly Environmental Improvements (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceiling lifts; wandering patients alerts; Shower</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Senior Friendly Care Initiatives (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission screening for seniors risk; Cohort ALC; Physical therapy through CCAC; Shared CCAC discharge role;</td>
</tr>
</tbody>
</table>

Hospitals were also asked to identify their most successful initiatives to improve clinical care for older patients. The level of response is both comprehensive and diverse. 87% of hospitals (20) identified more than 40 initiatives. This would appear to reflect a strong commitment to respond to the unique needs of hospitalised older patients across the North East.

Given the challenges associated with sustainable discharges for older patients, the self-assessment asked hospitals to identify discharge planning practices to support the needs of older patients.

A majority of hospitals reported using coordinated discharge follow up protocols, often including community partners. Many have also adopted a structured approach to discharge planning, checklists and protocols for discharge to outpatient services and primary care. Several hospitals expressed concern that limited access to home and community care across the region impacts the safety and sustainability of their discharge planning.

While several small hospitals have maintained physiotherapy services critical to assessment and interventions related to de-conditioning, concern has been expressed about eligibility for OHIP funding for outpatient physiotherapy in small community hospitals where access to community therapy services is limited.

**Figure 11: North East LHIN Discharge Planning Practice (C2.5)**

<table>
<thead>
<tr>
<th>Discharge Follow up (19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership with CCAC, incl. Home First; Discharge Summary to Family Physician; Discharge follow-up Phone calls; Seniors Mental Health follow-up; Home assessment with OT (2); Home assessment with OT; Convalescent Care; Follow up medical appt; Partnerships with Community Support Agencies; Referral to Aging at Home Programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Rounds (9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>incl. multidisciplinary discharge rounds with community partners</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GEM ass’t &amp; follow up;</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient education booklets</th>
</tr>
</thead>
</table>
### Summary Findings – Processes of Care

- **NE LHIN Hospitals** have demonstrated a strong commitment to improve clinical care for older patients. (40 initiatives across 20 hospitals)

- Hospitals have established both protocols and monitoring practices for 42% of the 13 risk factors associated with hospitalisation of the elderly in the self-assessment. There are potential care gaps for common geriatric issues arising in hospital, such as de-conditioning and dementia related behaviours (20% and 30%).

- There is a need to refine reporting requirements associated with designated clinical protocols in order that improved outcomes for hospital care can be realised.

- A number of innovative, targeted discharge programs have been successfully implemented for older patients. However, there is a concern that access to home and community care in the rural north impacts the safety and sustainability of discharges for older patients.

### Promising Practices: Processes of Care

- **Interdisciplinary model of restorative care** to address de-conditioning and functional loss;

- **Post-discharge telephone follow-up**

- **Instituted physiotherapy** to address mobility and falls in small community hospital

- **Establishing a standard for mobilisation for older patients for restorative care.**

- **Developing a Geriatric Emergency Management program** to reduce ED visits and repeat admissions.

- **The establishment of a comprehensive range of interdisciplinary geriatric programs** including day hospital, GEM and ACE Units.

- **The development of a Transition to Home Program** to allow more time for convalescence to support safe, sustainable discharges.
Part 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-centeredness, communication, diversity, satisfaction, and respect.

70% of hospitals reported strategies to inform and involve older patients and their families in decisions about their care. Many referenced patient and family centred approaches to care associated with the level of individual involvement and direct communication one might associate with small community hospitals. Others identified family conferences, and patient education to involve them in decisions about their care. While many of these appear to reflect processes geared to the overall patient population, several hospitals, particularly those co-located with long-term or continuing care, have developed senior-focused mechanisms such as advisory councils.

<table>
<thead>
<tr>
<th>Figure 12: NE LHIN Hospital Processes to Inform and Involve Older Patients and Family Members (C3-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Family Centred Care Care (8), ^n Incl. Chaplaincy Program, Ethical Program,</td>
</tr>
<tr>
<td>Family conferences (6)</td>
</tr>
<tr>
<td>Patient education to involve them in decisions about their care (4) ^n Admission Package, Educational booklets,</td>
</tr>
<tr>
<td>LTC Resident Councils,</td>
</tr>
<tr>
<td>Satisfaction Surveys</td>
</tr>
</tbody>
</table>

As noted previously (Figure 7) there is also a rich and diverse range of programs in place to respond to the cultural needs of francophone seniors and elders, particularly in the rural hospitals. While these include interpretation and other services comparable to those of other hospitals in Ontario, a significant proportion of hospitals have adopted policies related to bilingual serviced delivery and traditional healing.

A minority of hospitals (22%) reported having formal programs in place to address senior friendly care on topics ranging from elder abuse to the management of behaviour for persons with dementia. Gentle Persuasive Approaches and PIECES education in seniors’ mental health were most often referenced in this regard.

Many hospitals identified limited access to geriatric knowledge and expertise as a constraint on the extent to which training and education regarding the unique needs of older patients can be delivered. Strategies to address this concern and promote positive attitudes towards older patients and their caregivers will be important to the further development of a Senior Friendly Hospital Strategy for the North East LHIN.

Irrespective of designated programs and processes, rural northern hospitals, with their unique role in their communities, are well-positioned to champion person and family-centred care fundamental to the senior friendly hospital framework.
Summary Findings – Emotional and Behavioural Environment

- 70% of hospitals reported strategies to inform and involve older patients and their families in decisions about their care. Some have developed senior-focused mechanisms such as advisory councils.

- There is a rich and diverse range of programs in place to respond to the needs of Francophone seniors and elders in the North East, particularly in small community hospitals. A number of hospitals have adopted polices to support Traditional Healing.

- While many hospitals in the North East LHIN promote a patient-centred philosophy of care, 22% reported having formal education programs in place to address senior friendly care on topics ranging from elder abuse to dementia.

- Limited access to geriatric knowledge and expertise is a constraint on the extent to which training and education regarding the unique needs of older patients can be delivered across the North East LHIN.

Promising Practices: Emotional & Behavioural Support

- The integration of Traditional Healing programs into practice to respond to the needs of elders
- Build geriatric capabilities through participating in regional education sessions on geriatrics and geriatric consultations.
- Hospital wide-education in Gentle Persuasive Approaches and PIECES
- Provision of comprehensive hospital wide training and orientation to principles of rehabilitation for older patients.
- Adapting nursing orientation to include curriculum on delirium, dementia and depression.
Part 4: ETHICS IN CLINICAL CARE AND RESEARCH

Complex ethical issues arise daily when caring for older patients. It is therefore important for hospitals to ensure structures and processes are in place to enable practitioners to take a thoughtful and consistent approach to these challenges that balances risk and benefits for older patients. Twelve hospitals (43%) in North East LHIN reported being able to access an ethicist to advise in complex situations. While some hospitals report their size as a constraint to accessing ethics consultations, others indicate this role is more ably performed by the physician in a community hospital with a close knowledge of the patient and their perspectives.

Hospitals demonstrate a high degree of consistency in the types of ethical issues identified related to the care of older adults. Advance Directives and End of Life Care, conflicts between patients and family preferences, and competency to consent to treatment were identified as common issues for which ethics consultation might be arranged.

18 of 23 hospitals report having specific policies on Advance Care Directives. Although some hospitals as noted above, are able to access the support of an ethicist, most report this is considered in exceptional cases only, and most rely principally on in-house human resources to resources advise staff and patients.

Summary Findings – Ethics in Clinical Care and Research

- A majority of hospitals in the North East have specific policies on Advance Care Directives.
- Although a minority report being able to access an ethicist for consultation, some report this role is ably performed by the physician in a small community hospital with a close knowledge of the patient and their perspectives.
Part 5: PHYSICAL ENVIRONMENT

When asked to identify barriers to senior friendly care, 7 of 23 hospitals in the North East LHIN cited aspects of their physical environment. While hospitals report using environmental audits to inform capital planning, most referenced AODA design guidelines. There is a significant body of information regarding senior friendly environmental design\textsuperscript{11,12} and these principles go beyond generalized guidelines such as building code requirements or accessibility guidelines set forth in the Access to Ontarians with Disabilities Act (AODA). Whether planning for retrofit projects or entire site redevelopment, there is an opportunity to design and implement senior friendly physical features that can improve patient safety, comfort, and independence, while also boosting staff satisfaction and direct patient care time.

It is therefore important that hospital staff involved in capital development and planning have training and access to resources on Senior Friendly Design.

While some hospitals are anticipating major capital redevelopment to address the deficiencies of aging infrastructure, many are planning incremental improvements within the limits of their current resources. Both provide an opportunity to implement senior friendly design guidelines.

Many of these improvements will enhance the safe mobilization of older patients with the potential to reduce the risk of falls, improve coping and orientation for those with cognitive difficulty, and prevent unnecessary de-conditioning.

**Summary Findings – Physical Environment**

- The physical environment is identified as a barrier to senior friendly hospital care in the North East LHIN;
- Hospitals have planned significant design improvements through ongoing renovations undertaken within the limits of existing resources. These include improvements to way finding, washrooms, flooring, doors, and hallways which will enhance the safe mobilisation of older patients;
- There is an opportunity to integrate evidence-based Senior Friendly Design Guidelines into hospital capital planning.

**Promising Practices: Physical Environment**

- The recruitment of volunteer Ambassadors to assist with way finding;
Looking Ahead – Moving toward Senior Friendly Hospital Care in the North East LHIN

Alternate Level of Care pressures in hospitals have long been recognised as a symptom or consequence of health systems inadequately aligned with the needs of an aging population. While much of the focus for resolving these pressures has quite rightly been placed on community and long term care sectors, it is also acknowledged that the hospital experience of older patients, in itself, can contribute to outcomes that constrain safe and sustainable discharges and precipitate ALC pressures. This has been recognised in the ALC Strategy for the North East which identified the need develop processes of care to improve hospital performance in relation to older patients.

The Senior Friendly Hospital Framework, as a roadmap for quality improvement for the acute care of older patients serves as a potential resource to achieve the identified priorities of the North East LHIN to reduce wait times in the ER and the amount of time people wait in ALC beds, as well as the implicit goal of achieving system level outcomes for Aging at Home. The completion of the self-assessment is a critical first step. The expressed commitment of the North East LHIN to support partner hospitals in this journey and to mandate measurable objectives into their implementation plan will be essential to achieving system-wide outcomes.

To support effective implementation planning for the Senior Friendly Hospital Strategy, hospitals were requested to identify significant barriers and challenges to becoming more senior friendly. Consistent with the economic constraints experienced by many hospitals in the North East, financial support was recommended to support any proposed changes. While some hospitals tailored these requests to specific aspects of implementation such as training and education programs to designated human resource functions, some suggested no changes could happen without additional financial support.

It was interesting to note that in addition to expected resource constraints such as funding, physical plant and human resources, a number of hospitals identified lack of time as a barrier to change. At least some of this concern was attributed to the reality of small community hospitals with mixed services and multiple reporting and accountability requirements.

<table>
<thead>
<tr>
<th>Figure 14 : North East : Barriers and Challenges to more Senior Friendly Care (D.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>16</strong></td>
</tr>
<tr>
<td><strong>7</strong></td>
</tr>
<tr>
<td><strong>7</strong></td>
</tr>
<tr>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

A Summary of Senior Friendly Care in North East LHIN Hospitals
Despite the apparent uncertainties regarding the Senior Friendly Hospital Strategy and its implications for small rural hospitals in the North East, 83% of hospitals reported the Self-Assessment was important in renewing or reinforcing the importance and awareness of senior friendly hospital care. More than 45 senior friendly initiatives were identified, reflecting an ambitious agenda for Senior Friendly Hospital Care for the North East over the next three years. Four hospitals, as a result of the survey have made concrete plans to formally integrate senior friendly care into their corporate plans.

<table>
<thead>
<tr>
<th>Figure 15: North East Senior Friendly Care Priorities (D.3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optimize Senior Friendly Programs &amp; Services (13)</strong></td>
</tr>
<tr>
<td>Restorative care; early mobilization in medicine-surgery, continue current geriatric initiatives, Geriatric assessment service, Physician Assistant, Expand LTC outreach, Increase pt education related to medications, CDPM, HELP Program</td>
</tr>
<tr>
<td><strong>Promote Integrated Continuum of Care (9)</strong></td>
</tr>
<tr>
<td>Aging at Home, Community ALC strategy; Enhanced community capacity, Develop FHT, Open rebuild nursing homes, CCAC, Promote seniors supportive housing</td>
</tr>
<tr>
<td><strong>Enhanced Discharge Planning initiatives (9)</strong></td>
</tr>
<tr>
<td>ALC policy revisions; applying to 5 homes; RPN telephone follow up</td>
</tr>
<tr>
<td><strong>Promote Age-Friendly Education and Culture (5)</strong></td>
</tr>
<tr>
<td>Establish designated committee for care of the elderly, Consider change to program management, Establish seniors centre of excellence, Incorporate SF care into Strategic Plan, Train geriatric resources.</td>
</tr>
<tr>
<td><strong>Focus on Designated Clinical Protocols (5)</strong></td>
</tr>
<tr>
<td>Med reconciliation; Implement delirium surveillance with hip fracture initiative; Expand hand hygiene program; Fall risk prevention; Pressure ulcer prevention</td>
</tr>
<tr>
<td><strong>Improve Physical Environment; (4)</strong></td>
</tr>
<tr>
<td>incl ED expansion.</td>
</tr>
</tbody>
</table>

Hospitals identified specific monitoring plans and expected outcomes for each of these initiatives.

The main outcomes which were cited for the proposed senior friendly care initiatives, in order of frequency of reporting, included:

- Improved the safety and quality of care; (18)
- Improved patient flow and reduced ALC days; (10)
- Improved ER wait times and utilisation; (6)
- Implementation of Senior Friendly Strategies. (5)
The report also identified a number of clinical areas where there has been less thorough adoption of protocols and best practice. Functional decline can directly impact the ability of frail patients to return home safely, and this has a secondary but far-reaching effect on the health system, evident in emergency room congestion and ALC rates. Given this level of impact to the patient and to the health system, it is worthwhile to consider the implementation of clinical programs focused on the prevention of functional decline and, once in place, evaluate their impact on patient outcome and satisfaction.

Hospitals recognise that their collective efforts will not realise system-wide outcomes in the absence of a supported system-wide strategy. However, the Self-Assessment prompted a diverse range of perspectives on the possibility of such an approach. Some hospitals expressed some level of uncertainty or reservation about how the framework could be feasibly integrated into the context of rural northern hospitals and suggested the need for an incremental approach. On the other hand, others expressed great enthusiasm and readiness to move forward and have already undertaken major planning initiatives in senior friendly care.

Limited access to specialised geriatric knowledge and expertise, as well as designated human resources, were identified as significant barriers to the further development of a Senior Friendly Hospital Strategy for the North East.

Combined with the unique role of many rural and northern hospitals in coordinating access to a continuum of care for older patients, they are well-positioned to further develop their capacities for Senior Friendly care.

The successful flow of patients through the health system, particularly that of vulnerable seniors, depends on practices that promote a high quality of care in every health care setting, along with fluid transitions that enable health system integration. The Senior Friendly Hospital Framework is a lens for organizations to use to apply toward these system pressures, and also includes principles to promote a culture of high-quality, person-centred care. Through its culture, its practices, and its collaborations, 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.

The identification of senior friendly champion organizations – early and successful adopters of senior friendly care – across the North East LHIN and eventually across the province, can be an impetus for knowledge exchange and the sharing of innovation. Providing a convenient forum for this knowledge exchange will encourage and enable all organizations across the system to hone their own policies and practices. This could take the form of a web-based toolkit that has the capacity for expansion and interaction, or periodic knowledge exchange workshops inviting local and international experts. Working as a ‘system of innovation’ by facilitating opportunities for fruitful dialogue will serve to strengthen the practice of all hospitals in the province.
### Appendix 1: North East LHIN Responses to the Senior Friendly Hospital Self Assessment

<table>
<thead>
<tr>
<th>Question on Self-assessment Template</th>
<th>Aggregate Response Small Community (Mixed) Hospitals</th>
<th>Aggregate Response Small Community (Acute) Hospitals</th>
<th>Aggregate Response Large Community Hospitals</th>
<th>Aggregate Response for All NE LHIN Hospitals¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Does your hospital have an explicit priority or goal for senior friendly care in its strategic plan?</td>
<td>29%</td>
<td>0</td>
<td>0</td>
<td>22% Yes</td>
</tr>
<tr>
<td>C1.1. Has the Board of Directors made an explicit commitment to become a Senior Friendly Hospital organization?</td>
<td>25%</td>
<td>0</td>
<td>25%</td>
<td>9% Yes</td>
</tr>
<tr>
<td>C1.2. Has a senior executive been designated as the organizational lead for geriatric/care of the elderly initiatives?</td>
<td>43%</td>
<td>0</td>
<td>50%</td>
<td>39% Yes</td>
</tr>
<tr>
<td>C1.4. Do you have a designated hospital committee for care of the elderly? (does not include committees for a specific senior friendly initiative)</td>
<td>36%</td>
<td>0</td>
<td>25%</td>
<td>26% Yes</td>
</tr>
<tr>
<td>C2.1. 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>45%</td>
<td>28%</td>
<td>48%</td>
<td>42% of protocols &amp; metrics in place for confirmed risk areas</td>
</tr>
<tr>
<td>C3.1. Do your staff orientation and education programs have defined learning objectives for senior care?</td>
<td>50%</td>
<td>50%</td>
<td>25%</td>
<td>48% Yes</td>
</tr>
<tr>
<td>C3.2. Are age-sensitive patient satisfaction measures incorporated into hospital quality management strategies?</td>
<td>14%</td>
<td>25%</td>
<td>0</td>
<td>13% Yes</td>
</tr>
<tr>
<td>C3.3. What programs and processes do you have in place to help older patients feel informed and involved about decisions affecting their care?</td>
<td>71%</td>
<td>50%</td>
<td>75%</td>
<td>70% Yes in place</td>
</tr>
<tr>
<td>C3.4. What programs and processes do you have in place to support cultural diversity among seniors and their families?</td>
<td>64%</td>
<td>100%</td>
<td>100%</td>
<td>78% Yes in place</td>
</tr>
<tr>
<td>C3.5. 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>36%</td>
<td>25%</td>
<td>50%</td>
<td>39% Yes in place</td>
</tr>
<tr>
<td>C4.1. Does your staff have access to an ethicist to advise on ethical issues related to care of older patients?</td>
<td>43%</td>
<td>50%</td>
<td>75%</td>
<td>52% Yes</td>
</tr>
<tr>
<td>C4.2. Does your hospital have a specific policy on Advance Care Directives?</td>
<td>79%</td>
<td>50%</td>
<td>100%</td>
<td>78% Yes</td>
</tr>
<tr>
<td>C5.1. Has your hospital conducted any senior friendly environmental audits of physical space using peer-reviewed guidelines (e.g. RGP audit, CodePlus or other)?</td>
<td>21%</td>
<td>25%</td>
<td>25%</td>
<td>22% Yes</td>
</tr>
</tbody>
</table>

¹ All LHIN Hospitals includes large community (hub), small community (acute & mixed) and complex continuing care hospitals
Appendix 2: North East LHIN - Summary of Individual Senior Friendly Hospital Recommendations

Summary of Senior Friendly Recommendations:
North East LHIN

- Organisational Support: 17
- Processes of Care: 21
- Emotional & Behavioural Environment: 4
- Ethics in Clinical Care & Research: 0
- Physical Environment: 5
<table>
<thead>
<tr>
<th>Organisational Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendations</strong></td>
</tr>
<tr>
<td>1) The Health Centre is in the process of updating their strategic plan. Consideration of a more focused approach to senior friendly care within the plan could potentially enhance the impact of senior friendly care programs in place.</td>
</tr>
<tr>
<td>2) The hospital has adopted a wide range of care protocols that target areas of risk for the hospitalization of older patients. Consideration should be given to the use of established indicators to assess the efficacy of these interventions at the clinical and organisational level.</td>
</tr>
<tr>
<td>3) An extensive range of clinical protocols targeting areas of risk for the hospitalization of older patients has already been adopted by the hospital. Consideration of using age-sensitive indicators to support these protocols could serve to enhance the clinical and organizational impact of these interventions.</td>
</tr>
<tr>
<td>4) It is hoped that the hospital will participate in regional discussions to clarify the extent and manner by which the Senior Friendly Hospital Framework can be adapted to the context of rural northern hospitals.</td>
</tr>
<tr>
<td>5) Subsequent to the redevelopment of its new role, the hospital has expressed an interest to further develop its focus on senior friendly care. The hospital is urged to participate in discussions with regional partners to determine how the Senior Friendly Hospital Framework can be best adapted to the needs of rural and northern hospitals.</td>
</tr>
<tr>
<td>6) There is an opportunity identified in the Self-Assessment, to further engage the Board and organisation in developing an enhanced focus on seniors’ friendly care. The broad range of service the hospitals offer, from acute to continuing care, provides a strong foundation for further development of senior friendly care. The XX is urged to participate in regional discussions regarding the manner in which Senior Friendly Hospital Care can be adapted to the context of rural northern hospitals.</td>
</tr>
<tr>
<td>7) As the hospital explores further opportunities to develop senior friendly care, the Elder Care Committee may wish to consider the Senior Friendly Hospital Framework as a common pathway to guide their planning and program development.</td>
</tr>
<tr>
<td>8) In light of the hospitals position that it is unable to proceed with any enhancements to seniors friendly care, it is urged to participate in discussions with regional partners and the North East LHIN to discuss the potential to adapt the Senior Friendly Strategy to the context of rural northern hospitals.</td>
</tr>
<tr>
<td>9) In light of the hospital’s position that it is unable to proceed with any enhancements to senior friendly care, it is urged to participate in discussions with regional partners and the North East LHIN to discuss the potential to adapt the Senior Friendly Strategy to the context of rural northern hospitals.</td>
</tr>
<tr>
<td>10) In light of the hospital’s involvement in hospital care of the elderly, it is urged to</td>
</tr>
</tbody>
</table>
participate in discussions with regional partners and the North East LHIN to evaluate the potential to adapt the Senior Friendly Strategy to the context of rural northern hospitals.

11) The above-mentioned programs appear to be supported by a good foundation of nursing and interdisciplinary providers. The Self-Assessment has not identified designated medical leadership with expertise in geriatrics or care of the elderly. This can be a key factor in geriatric program effectiveness which might be considered in future human resource planning.

12) Given the ambitious program in developing geriatric capabilities within the hospital, consideration might be given to designating new or existing interdepartmental structures or processes to coordinate their implementation to ensure organisation-wide impact.

13) The hospital has expressed uncertainty about the impact of a focused approach to the needs of older patients, in the context of rural northern hospitals. Consideration should be given to participate with regional partners and the North East LHIN to clarify how the Senior Friendly Hospital Strategy might be adapted to small northern hospitals, including implications for staff support.

14) The hospital is encouraged to proceed with its proposed plan to integrate a senior friendly care component into its revised strategic plan, and to designate an interdepartmental committee to coordinate and review care of the elderly within the hospital.

15) In light of the hospital’s express interest in further developing a senior friendly strategy, it is suggested they participate with regional partners and the North East LHIN to clarify and refine an appropriate approach for the North East.

16) The responses in the Self-Assessment express concern and uncertainty about the implications of integrating senior/elder friendly care in the context of rural northern health facilities. Given that elders are a primary user of their services, the Weeneebayko Heath Authority is urged to collaborate with the North East LHIN and regional partners to consider and clarify how this might best be realised.

17) The Health Centre is to be commended for recognizing that organisational processes and structures must be established to achieve organisation-wide outcomes for senior friendly care. It is hoped over time the scope of the ALC working group will evolve to encompass a broader scope of senior friendly care than hospital diversion which is typically the mandate of such groups.

**Processes of Care**

1) The Health Centre has adopted an excellent range of senior friendly care strategies and has demonstrated a strong commitment to enhance the care of older patients. This could be further enhanced through broadening the scope of protocols and indicators which respond to key risk factors for the hospitalisation of older patients, such as delirium and/or dementia.

2) The hospital has proposed to introduce a discharge follow up service and a Nurse
A Summary of Senior Friendly Care in North East LHIN Hospitals

Practitioner for in-home assessment and intervention. Both initiatives have the potential to improve the quality of care and to reduce the utilisation of hospital services, and should therefore be encouraged.

3) The hospital has proposed an expansion and redevelopment of the ED. As this expansion proceeds it will provide an opportunity to assess the potential to optimize geriatric emergency management through the integration of both Senior Friendly Design Guidelines, and evidence-based screening tools such as the ISAR.

4) The hospital has proposed the recruitment of a physiotherapist to complement their interdisciplinary team. This will provide an excellent opportunity to establish protocols to mitigate the effects of de-conditioning older patients experience as a result of hospitalization, and as a result, reduce potential barriers to sustainable discharges.

5) The Health Centre has proposed a redesign of emergency services. This presents an opportunity to consider the integration of Senior Friendly Design Guidelines, which have been tailored to ED implementation. The implementation of high-risk screening protocols supported by targeted interventions can potentially reduce repeat visits in the ER as well.

6) The Health Centre has adopted a broad range of clinical protocols associated with areas of risk for the hospitalization of the elderly. These can be supported by the adoption of appropriate indicators the Quality Assurance Committee might consider in their ongoing review of these programs.

7) The hospital has indicated it is interested in exploring the adoption of high-risk screening protocols for older patients in the ER. The adaptation of alternative approaches to geriatric emergency management holds significant potential to improve the safety and quality of care both within the ER and across the organisation. As the opportunities permit, the hospital is encouraged to pursue this direction.

8) The hospital has indicated there is an interest in introducing Geriatric Emergency Management nursing. Evidence-based GEM intervention models have proven effective in reducing ER visits and repeat admissions. Should the opportunity to proceed arise, this will provide an opportunity to further develop senior-focused care and expertise within the hospitals.

9) In addition to the development of post-discharge convalescent care programs, consideration might be given to further expand the adoption of clinical protocols to facilitate mobilization and reduce the risks of de-conditioning associated with hospital care, which in turn limit potential options for safe, sustainable discharges.

10) The proposals to further enhance geriatric programming with the HELP program geriatric assessment hold the potential to achieve both quality and utilisation outcomes for frail older patients in the hospital.

11) Consideration could be given to expand the current range of senior friendly clinical
### Protocols (Practice Guidelines)

Protocols (practice guidelines) to include risk actors such as delirium, de-conditioning and/or dementia. Evidence-based guidelines in these domains have the potential improve quality while reducing utilization of hospital services.

### 12) The Hospital

The hospital is commended for the breadth and scope of senior friendly care initiatives it has proposed for the next three years.

### 13) Consideration

Consideration should be to expand the scope of clinical protocols and practice guidelines that are adopted, that are known to mitigate the significant risks associated with hospitalisation of older patients.

### 14) Given the Level

Given the level of hospital services directed towards older patients, consideration should be given to increase the range of clinical protocols designed to mitigate known risks for hospitalisation of the elderly.

### 15) While the Hospital

While the hospital has initiated a range of clinical practice guidelines, consideration could be given to expand the range of adoption for key areas of risk, and to support their implementation with active monitoring with indicators.

### 16) Given the High Concentration

Given the high concentration of older patients, consideration could be given to expanding the scope of clinical protocols and indicators responding to known areas of risk for the hospitalization of older patients. Given the level of OR activity and the very high proportion of older patients using the ED (33% in 2009/10), peri-operative delirium surveillance and high-risk screening and intervention in the ER might be considered.

### 17) While the Hospital is to Be Recognised

While the hospital is to be recognised for its initiative in developing new geriatric programs, consideration should be given to establish relevant indicators to support ongoing performance management as these programs evolve through the developmental phase.

### 18) The Self-Assessment

The Self-Assessment indicates a rate of adoption of 15% for clinical protocols and indicators targeting known risk factors for hospitalization of older patients. Consideration should be given to enhance the range of practice guidelines which are adopted as part of the hospital's safety and quality improvement planning.

### 19) While a Broad Range

While a broad range of clinical practice guidelines relevant to the care of older patients has been adopted, their effectiveness would be supported with the integration of more active monitoring using relevant indicators for the respective guidelines.

### 20) While the Hospital has Adopted

While the hospital has adopted seven clinical protocols and has three others are in progress, the efficacy of these interventions would be supported through active monitoring with established indicators.

### 21) While the Hospital has Adopted

While the hospital has adopted 6 clinical protocols that respond to significant risk factors in hospitalization of the elderly, caution should be exercised to support effective implementation in order to ensure anticipated results are achieved. The integration of active monitoring with relevant indicators into the Health Centre’s Quality Performance Management should be considered in this regard. This caution is expressed as indicators.
for fall rate and pressure ulcer prevalence were not included in the Self-Assessment.

### Emotional & Behavioural Environment

1) The Health Centre is in the process of updating their staff orientation. An increased emphasis on the unique aspects of senior friendly care would further strengthen the geriatric capabilities of their team and build on current knowledge and expertise.

2) The hospital has proposed to enhance patient education upon discharge and monitor progress in this regard through NRC Picker survey results. Consideration could be given to review this information by age cohort to determine how these strategies respond to the specific needs of older patients.

3) The need to further develop geriatric capabilities with recruitment and training as suggested by the hospital is acknowledged. The XX Hospital is encouraged to consult with regional partners and the North East LHIN to discuss innovative strategies and approaches to recruit and retain needed geriatric expertise.

4) A strong effort has been made to develop organisation-wide education and training programs in senior friendly care. The hospital should be encouraged to continue and enhance these efforts as their programs evolve.

### Ethics in Clinical Care and Research

### Physical Environment

1) A clearly articulated Accessibility Plan has been developed in compliance with the AODA. Future planning could be enhanced by the consideration of enhanced Senior Friendly Design Guidelines that reflect the unique needs of older patients.

2) According to the Self-Assessment it appears the hospital plans to conduct renovations on their inpatient unit in the near future. This could be further enhanced by consideration of Senior Friendly Design Guidelines that, while reflecting the unique needs of older patients, would improve accessibility for all patients.

3) The Self-Assessment suggests an ambitious plan to renovate and renew the hospital. Reference to Senior Friendly Design Guidelines could ensure these improvements go beyond basic accessibility requirements to more fully respond to the needs of older patients using XX Hospital.

4) Planning is underway to redevelop the aging hospital facility. When this proceeds, consideration should be given to incorporate evidence-based Senior Friendly Design Guidelines into the planning to ensure the new building responds to the unique needs of its older patient population.

5) Although the hospital indicates it complies with the AODA, consideration might be given to integrating Senior Friendly Design Guidelines into ongoing renovations and equipment acquisition.