

Getting Started

TOOLKIT

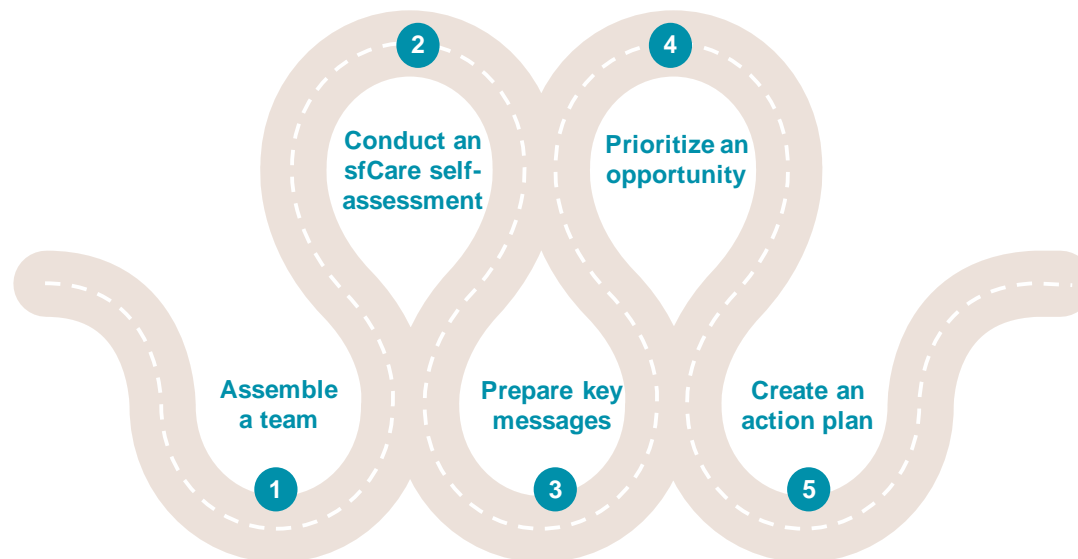
A roadmap and resources for implementing senior friendly care in organizations across all sectors.



Implementation Roadmap

sfCare is a Continuous Improvement Journey

Regardless of your type, size, or number of organizations, or where you're starting from, this toolkit will help you assess where you are on your senior friendly care (sfCare) journey and provide practical resources for implementing change. When you implement senior friendly change ideas, your roadmap will look something like this...



Tips



- ✓ **The best time to start is now!** Even if there are system pressures or time challenges, get a team together, generate ideas and start planning for the implementation.
- ✓ Learn more about what sfCare looks like by watching a 5min video or flipping through the PowerPoint.



Implementation Roadmap

1 Assemble a Senior Friendly Team

- If you don't have an sfCare team/council/committee/working group in your organization, you will want to start by designating an Executive Sponsor and a Team Lead to be accountable for sfCare.
- The team should comprise interprofessional staff at different levels of the organization who can devote time to planning the implementation of sfCare, as well as older adults and caregivers. Some or all of the team members may be designated as Front-Line Senior Friendly Champions

Team Composition and Roles

Role in the organization	Role in the implementation team	Description of implementation roles
Senior Leader	Executive Sponsor	Paves the path for success – meets with the team lead and front line champion(s) on a regular basis to establish goals, hold the team accountable to them, and remove barriers to achieving them
Front-line Healthcare Provider	Team Lead	Coordinates and implements – schedules meetings, creates and updates an action plan, and co-leads implementation activities with the front line champion(s)
Front-line Healthcare Provider and Older Adult and Caregiver Advisors	Front-Line Senior Friendly Champion(s)	Implements – creates the action plan with the team lead and co-leads implementation activities <i>and/or</i> Champions – opinion leader / change influencer



Tips

- ✓ Reach out to people in your organization(s) who have been involved in previous senior friendly care initiatives, or who have interest or experience in the care of older adults.
- ✓ Establish linkages between the senior friendly team, quality improvement team, and any other teams working on related initiatives and priorities.
- ✓ Connect with your local [Regional Geriatric Programs \(RGPs\)](#) / [Specialized Geriatric Services \(SGS\)](#) to support your work.
- ✓ Build trust within the senior friendly team. [Ways to Build Trust Within Senior Friendly Care Committees](#).
- ✓ Use Health Quality Ontario's practical tips to [Take your patient partnering to the next level](#)

2 Conduct an sfCare self-assessment

The self-assessment tool helps organizations in all sectors highlight their strengths and opportunities. It can be used in a single organization or across multi-site organizations.

Who should assess

2 members of your sfCare team, such as the Team Lead and a Front-Line Senior Friendly Champion. Assessors should feel comfortable asking questions about sfCare across the organization.

How to gather the information

The assessment is meant to be a snapshot of a moment in time and not an exhaustive effort where every area of practice is examined in detail. Document whatever you know or can easily find. It's ok if you don't have all of the answers. This is not a test. Whatever you find will help to identify strengths and opportunities.

- Review the 18 questions in the [SfCare Self-Assessment Tool](#) and plan for how to gather the information.
 - Multi-site or multi-partner organizations: complete self-assessments for each discrete organization within the umbrella organization. If an organization comprises more than 1 sector (such as a hospital and long term care home) complete an assessment for each sector within that organization.
 - Hospitals: visit the ED and 2 units (medical and surgical that provide care to older adults. Speak to HR, Education, Ethics, and Quality Improvement departments as needed. While the tool is not meant to assess specialized geriatric services, you will want to speak to geriatric specialists to see how they can support your sfCare initiative.

How to submit the assessment

- You can complete the assessment over time by clicking "Save & Quit". When you are finished the assessment, click "Submit".
- After clicking "Submit"
 - You will see a message in green indicating that your assessment has been successfully submitted. (If this message does not appear, the assessment has not been submitted. Please email for support: info@rgptoronto.ca).
 - Your assessment will be reviewed by the RGP of Toronto, and a report will be emailed to you, generally within 5 business days. [See a sample report](#).



Tips

- ✓ **Keep a printed copy of the assessment before saving or submitting!** Technical glitches are rare, but can happen. Click "Print" to save a copy before clicking "Save & Quit" or "Submit"
- ✓ Do a self-assessment whenever you want to prioritize opportunities. Generally every 1-2 years.
- ✓ To identify opportunities across multi-site or multi-partner organizations, collate the results on the first page of each self-assessment report. For regions, aggregate the data across sectors.

3 Prepare Key Messages

- Messages about sfCare should relate to the priorities of leaders and staff across your organization.
- Use the 5-minute introduction videos on page 3 which describe what senior friendly care is and why it's important; the needs of older adults; and what executives and staff can do to make a difference. You can also create your own messages by adapting the PowerPoints or the [sfCare Policy Briefs](#). If you are adapting content, please remember to credit the RGP of Toronto as the author

4 Prioritize an Opportunity

- Review your sfCare self-assessment report and select 1 area of opportunity to work on.
- Focus on one process of care to start, such as delirium or mobilization, and decide what needs to change to support your selected process of care in the remaining [sfCare Framework domains](#).
An example of what this looks like for [delirium](#). An example of what this looks like for [mobilization](#).
- Select one or more change ideas to work on by:
 - reviewing feedback from older adults (satisfaction surveys, advisory panels, etc.)
 - asking frontline staff, patients, and caregivers for change ideas, and what they suggest starting with
 - reviewing the implementation resources in this toolkit (pages 7-16).

5 Create an Action Plan

- Consider what's most important to the people involved in the process and what might be easiest to implement (quick wins).
- Use the [sfCare 5Ws Worksheet](#) to explore the details, scope, and feasibility of the change ideas (what, when, where, why and who), to inform the action plan.
- Use the [sfCare Action Plan Template](#) to capture:
 - **Improvement aim** – what are you trying to accomplish? Be specific: use an indicator and add a timeframe for when this will be achieved.
 - **Pilot area** – where will you pilot the change? Pick a unit or a population of patients that you think provide the right environment for achieving a quick win.
 - **Team** – who will drive this work forward?
 - **Change ideas** – what do you want to implement at the point of care? Be specific about what actions need to be done differently, by who, and in what setting.
 - **Process Measures** – what will you measure to see if the changes are successful?
 - **Implementation Tasks** – what tasks need to be done, by who and by when in order to plan for and test change ideas? The sfCare Action Plan Template includes tasks for each component of your test of change: plan, do, study, act (PDSA)

Implementation Resources

The sfCare self-assessment and implementation resources are based on 10 recommendations developed from the [sfCare Framework](#).

sfCare Framework



10 Recommendations

- 1 Commitments to the sfCare framework are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives.
- 2 Guiding documents (such as policies, standards, procedures, guidelines, care pathways etc.) reflect senior friendly values and principles; promote older adult's health, autonomy, dignity and participation in care; and ensure that an older adult will not be denied access to care or the opportunity to participate in research based solely on their age.
- 3 Education and/or training is provided to all staff on senior friendly topics.
- 4 Care delivery partners from all sectors have been identified, and collaborative processes exist to ensure information sharing and seamless transitions for older adults across the healthcare continuum.
- 5 Interprofessional assessment and care is guided by evidence-informed practice to optimize the physical, psychological, functional, and social abilities of older adults.
- 6 The older adult/caregivers are provided with information to let them know what to expect in their care, help them make decisions, and better self-manage their conditions.
- 7 The care plan, goals, and expected results of care are developed in collaboration with all members of the care team and the older adult/caregivers and aligned with the older adult's preferences.
- 8 A system is in place to measure the experience and outcomes of older adults and make improvements based on the results.
- 9 An approach is in place to support care providers and the older adult/caregivers in challenging ethical situations.
- 10 Structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being.

Implementation Resources

There are many resources available to support senior friendly care initiatives. The resources in this section are a curated selection of tips and practical tools that are aligned with the 10 recommendations.

- 1 **Commitments to the sfCare framework are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives.**



Tips



- ✓ Align senior friendly care initiatives in the organization. This should be included in the organization's strategic plan, operating plan, and/or corporate goals and objectives (such as a Quality Improvement Plan).
- ✓ Engage senior leaders and the board by providing information on senior friendly care. **Resources 1-3**
- ✓ Encourage senior leaders to do walkabouts in the areas of the organization where care is provided to older adults. **Resource 4**
- ✓ Where appropriate, include skills and experience in the care of older adults in job postings and performance reviews.
- ✓ Include visual reminders across the organization that sfCare is a priority. **Resource 5-6**

Resources



1. [Introduction Slides – sfCare Framework + Getting Started Toolkit \(PPT\)](#)
2. [An introduction to sfCare: A primer for executives \(5 min video - HTML\)](#)
3. [sfCare Framework \(PDF\)](#)
4. [Seniors Care Network's Senior Friendly Hospital Walkabout Framework \(PDF\)](#)
5. [sfCare organization poster](#)
6. [sfCare process of care posters](#)



Implementation Resources

- 2 Guiding documents (such as policies, standards, procedures, guidelines, care pathways etc.) reflect senior friendly values and principles; promote older adult's health, autonomy, dignity and participation in care; and ensure that an older adult will not be denied access to care or the opportunity to participate in research based solely on their age.



Tips



- ✓ Use a “senior friendly lens” to ensure that person-centred principles are applied and that stereotypes about aging and the ability of older adults don’t lead to discriminatory treatment. **Resources 7-9.** To apply a “senior friendly lens”, ask the following questions:
 - Do the words portray older adults in a positive light?
 - Do the words presume that older adults are capable and competent, while accommodating for frailty, or limitations and disabilities (such as cognitive deficits, mobility needs, or sensory deficits) in a respectful way?
 - Is the policy/procedure/guideline free from age restrictions (for treatment or research) where there is no clinical evidence to support such a restriction?
- ✓ Implement policies for senior friendly processes of care. **Resource 10**
- ✓ Implement policies that recognize and support caregivers as partners. **Resource 11**

Resources



7. [Kingston General Hospital's Policies Supporting Patient and Family Centred Care \(PDF\)](#) Provides 3 policy examples which illustrate the use of language that is inclusive of patients, families and their needs and perspectives.
8. [Alzheimer Society's Person-Centred Language Guidelines \(PDF\)](#) Provides a list of non-patient-centred language, rationale for why not to use it, and words to use instead.
9. [WHO Quick Guide to Avoid Ageism in Communication \(PDF\)](#)
10. [AGS/ACEP/ENA/SAEM's Geriatric Emergency Department Guidelines \(PDF\)](#) Provides list of 13 suggested policies for the ED, and samples of 5 of them on pages 14-31
11. [Ontario Caregiver Organization's Caregiver ID](#), identified as a leading practice as part of Essential Care Partner programs. Includes templates and implementation case examples.



3

Education and/or training is provided to all staff on senior friendly topics.



Tips



- ✓ Ensure that all staff complete sfCare introductory training during orientation as well as on a regular cycle (refresher training required periodically). At a minimum, this would include an overview of the sfCare Framework and sensitivity training (i.e. general awareness on aging and the special needs of older adults with frailty, communication, and ageism.) **Resources 12-14**
- ✓ Determine which staff require additional education and provide an opportunity for training during orientation as well as on a regular cycle (refresher training required periodically). Consider providing education on senior friendly clinical topics such as: delirium, mobility, continence, nutrition, pain, polypharmacy, and social engagement. **Resources 15-20**

Resources



12. [An introduction to sfCare: top tips for all staff \(5 min video - HTML\)](#)
13. [Change Foundation + The Michener Institute's "Experiencing Aging" videos \(HTML\) 5-6 min.](#) videos for primary, home and emergency care settings.
14. [Health Force Integration Research and Education for Internationally Educated Health Professionals' free online course "The aging population" \(HTML\)](#). Perspectives on aging, ageism, and diversity, and strategies for communication.
15. [sfCare Learning Series for Clinicians \(HTML\)](#) Education modules (e-learning and decks) posters and handouts on 7 clinical topics.
16. [sfCare Learning Series for Personal Support Workers \(HTML\)](#) Supervisor's guide and personal support worker pocket guide on 7 clinical topics.
17. [The SF7 Toolkit \(PDF\)](#) Supports clinical best practices for healthcare providers across the sectors of care and includes self-management tools for older adults and their caregivers on 7 clinical topics.
18. [Registered Nurses' Association of Ontario \(RNAO\) e-learning – Older Adults \(HTML\)](#) Delirium, Dementia and Depression; and Preventing and Addressing Abuse and Neglect.
19. [The Regional Geriatric Programs of Ontario's Competency Framework for Interprofessional Comprehensive Geriatric Assessment \(PDF\)](#) This framework helps health professionals prepare themselves to deliver interprofessional comprehensive geriatric assessments and interventions, and work effectively in a specialized geriatrics environment.
20. [Regional Geriatric Programs \(RGPs\) / Specialized Geriatric Services \(SGS\) educational offerings \(HTML\)](#) An array of educational programming related to the care of older adults living with complex health conditions.

- 4 Care delivery partners from all sectors have been identified, and collaborative processes exist to ensure information sharing and seamless transitions for older adults across the healthcare continuum.



Tips



- ✓ Connect with each care delivery partner and with older adults/caregivers to collaborate on:
 - what information is required (such as contact information for older adults/caregivers and healthcare providers, medical history, medication reconciliation, assessments, test results, care plan)
 - when the information will be shared (for example, within 24 hours of transition),
 - how the information will be shared (print, mail, fax, phone, electronic record etc.),
 - and who is responsible for sending, receiving, and following up on the information
- ✓ Create written guidelines and templates for information sharing. **Resources 21-25**
- ✓ Evaluate the transition process by actively soliciting feedback from staff and older adults/caregivers. **Resource 25**

Resources



21. [Canadian Medical Protective Association's \(CMPA\) Handovers – Transferring Care to Others \(HTML\)](#) This good practices guide provides strategies for improving handovers and examples of structured communication tools that can be used for handovers.
22. [Health Quality Ontario's \(HQP\) Evidence Informed Improvement Package for Transitions of Care \(PDF\)](#)
23. [RNAO's Best Practice Guidelines for Care Transitions \(HTML\)](#)
24. [UHN OpenLab's Patient Oriented Discharge Summaries \(PODS\) \(HTML\)](#)
25. [The Change Foundation's Interventions and measurement tools related to improving the patient experience through transitions in care: A summary of key literature \(PDF\)](#)
Pages 12-15 provide examples of evaluation questions to use for measuring effectiveness of transitions.

- 5** Interprofessional assessment and care is guided by evidence-informed practice to optimize the physical, psychological, functional, and social abilities of older adults.



Tips



- ✓ Focus on preventable harm by prioritizing senior friendly processes of care such as delirium prevention and early mobilization.
 - In all sectors, implement a standardized process for interprofessional DELIRIUM screening, prevention, management, and monitoring. **Resources 26-31**
 - In all sectors, implement a standardized process for interprofessional FUNCTIONAL DECLINE screening, prevention, management, and monitoring. **Resources 28-34**

Resources



26. [Ontario's Delirium Quality Standard Practical Implementation Guide \(PDF\)](#)
27. [SFH Delirium Toolkit \(DOCX\)](#) Designed for hospitals, but many resources are applicable or adaptable across sectors.
28. [sfCare Learning Series for Clinicians \(HTML\)](#) Education modules (e-learning and decks) posters and handouts on 7 clinical topics.
29. [sfCare Learning Series for Personal Support Workers \(HTML\)](#) Supervisor's guide and personal support worker pocket guide on 7 clinical topics.
30. [The SF7 Toolkit \(PDF\)](#) Supports clinical best practices for healthcare providers across the sectors of care and includes self-management tools for older adults and their caregivers on 7 clinical topics.
31. [WHO's ICOPE \(Integrated Care for Older People\) Handbook: Guidance on person-centred assessment and pathways in primary care \(PDF\)](#). Practical guidance for community and primary care providers on 6 priority conditions associated with declines in intrinsic capacity.
32. [SFH Functional Decline Toolkit \(DOCX\)](#) Designed for hospitals, but many resources are applicable or adaptable across sectors.
33. [MOVE Canada Implementation Playbook \(HTML\)](#) Provides implementation tools such as print ready posters and pamphlets as well as training materials to promote early mobilization of hospitalized older adults.
34. [SLoT Stretch Lift or Tap program \(HTML\)](#) A philosophy and a set of tools designed to encourage older adults to embed functional exercise in their daily activities.

- 6** The older adult/caregivers are provided with information to let them know what to expect in their care, help them make decisions, and better self-manage their conditions.



Tips



- ✓ Ensure that senior friendly principles are used for verbal communication. **Resource 35**
- ✓ Ensure that written information uses senior friendly principles. Review all resources (including business cards, letterhead, appointment reminders, patient information sheets etc.) and revise as necessary to ensure font size is large enough, wording is easy to understand, and the information provided is complete. **Resources 36-38**
- ✓ Ensure that written information is provided on applicable processes of care and that the content is specific to older adults and caregivers (such as delirium, mobility, continence, nutrition, pain, polypharmacy, and social engagement). **Resource 38**
- ✓ Ensure that up-to-date information about programs/services is available to healthcare providers, older adults, and caregivers. **Resource 39**
- ✓ Make referrals to programs/services in a way that best supports the older adult: make the referral for them; call for information or registration if needed; and/or provide written information for the older adult to review and follow up on as they would like.
- ✓ Review programs and services regularly with older adults/caregivers, especially when there is a change in health status – are they using the programs/services? Do they like them? Do they require additional programs or services?

Resources



35. [National Institute on Aging's Talking With Your Older Patient \(HTML\)](#). Tip sheet for communicating with older patients.
36. [Canadian National Institute of the Blind's \(CNIB\) Clear Print Accessibility Guidelines \(PDF\)](#). Provides guidelines for visual legibility of printed materials.
37. [National Institute On Aging's \(NIA\) Making Your Printed Health Materials Senior Friendly \(PDF\)](#). Provides guidance for visual legibility as well as appropriate language for print materials.
38. [Resources for older adults and caregivers \(HTML\)](#). A curated list of practical resources including ready-to-use self-management handouts and a caregiving strategies course and handbook.
39. [211 Helpline and website \(HTML\)](#). Provides connection to Ontario's community and social services. 211 helpline is available to find support 24/7 and has interpretation for over 150 different languages.



- 7** The care plan, goals, and expected results of care are developed in collaboration with all members of the care team and the older adult/caregivers and aligned with the older adult's preferences.



Tips



- ✓ Ensure that there is a process in place for goal setting with the patient. Review goals regularly (such as when there is a change in health status). **Resource 40**
- ✓ Ensure that there is a process in place for creating a written coordinated care plan (CCP) which includes healthcare providers across the continuum of care **Resource 41**
- ✓ Ensure that the care plan is readily accessible (in printed format) to the older adult and caregiver and all healthcare providers across the continuum of care.

Resources



- 40. [Patient Priorities Care Implementation Toolkit \(HTML\)](#) Patient Priorities Care (PPC) helps patients, caregivers and clinicians focus decision making and healthcare on patients' own health priorities.
- 41. Health Links' Coordinated Care Planning (CCP)Tools:
 - [How to Document a CCP \(PDF\)](#)
 - [CP User's Guide \(PDF\)](#)
 - [CCP Template \(DOCX\)](#)

My Health Priorities Summary

Step 1: What Matters Most (see page 6)

1. 2.

Step 2: Health Goal—The specific activity you most want to do that is realistic and doable with your health care (see page 12)

I want to (insert specific activity) _____
for/in/over (include time frame) _____
If needed, revise health goal: _____

Step 3: Most Bothersome Symptoms or Health Problems (see page 16)

1. 2.

Step 4: Current Health Care Tasks and Medications (see page 19)

Helpful

Tasks: 1. 2.

Medications: 1. 2.

Burdensome

Tasks: Why burdensome?

1.

2.

Medications: Why burdensome?

1.

2.

Step 5: The One Thing to Focus On (see page 24)

The one symptom, health problem, health task, or medication I most want to focus on is _____ so that I can (insert health goal) _____ more often or more easily.

Summary |

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- 8 A system is in place to measure the experience and outcomes of older adults and make improvements based on the results.



Tips

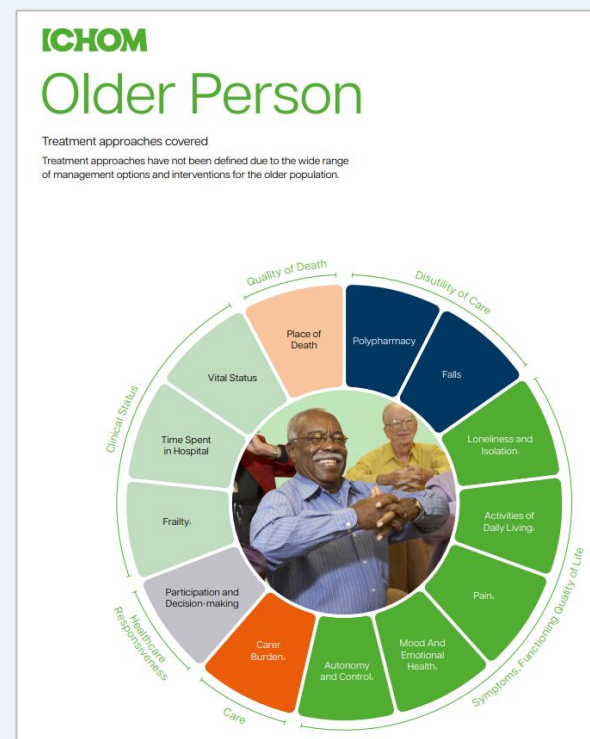


- ✓ Measure outcomes for Ontario quality standards which relate to processes of care of older adults, such as Delirium, Dementia, Behavioural Symptoms of Dementia, Hip Fracture, Palliative Care, and Pressure Injuries.
Resource 42
- ✓ Measure outcomes that matter most to older adults.
Resource 43
- ✓ Create formal and informal feedback mechanisms that are accessible to older adults and caregivers. Ensure that there are a variety of format options (online, paper, verbal), and that formal surveys are not burdensome to complete (not too lengthy). For online tools, allow questions to be skipped.
- ✓ Ensure a process is in place to regularly review feedback and to take action on the feedback.

Resources



- 42. [HCO's Quality Standards \(HTML\)](#)
- 43. [International Consortium for Health Outcomes Measurement's \(ICHOM\) Standard Set of Outcome Measures for Older Person \(HTML\)](#)



- 9 An approach is in place to support care providers and the older adult/caregivers in challenging ethical situations.



Tips



- ✓ Ensure that an approach (such as a framework or process) is in place that identifies how to work through ethical issues, and that care providers, older adults and caregivers know how to access the resources.

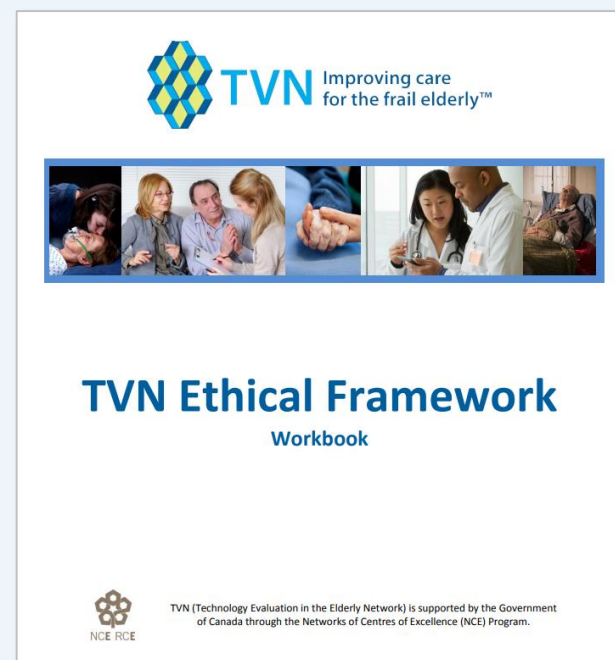
Resource 44-45

- ✓ Consider ethical issues when developing policies or procedures that have an impact on the care and health outcomes for older adults by ensuring that older adults, caregivers, and healthcare providers who specialize in the care of older adults are involved in the process. For example, policies on family/caregiver/care partner presence during a pandemic.

Resources



44. [Trillium Health Partners' IDEA: Ethical Decision - Making Framework \(PDF\)](#) An example of one organization's framework and worksheet to work through ethical issues.
45. [TVA's Ethical Framework Workbook](#) Guidance on operationalizing an ethical framework. Includes case studies of older adults.



- 10** Structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being.



Tips



- ✓ Create a checklist of physical environment requirements which meet s the needs of older adults in your organization. **Resources 46-48.** NOTE – make sure the checklist complies with applicable government standards in your region.
- ✓ Ask older adults and caregivers for their suggestions. E.g. - an older adult who experienced delirium in hospital said that the electronic clock/calendar was helpful, but it wished the name of the hospital had been on it to help orient him to where he was.

Resources



46. [The World Health Organization's Age-Friendly Primary Health Care Centres Toolkit \(PDF\)](#) Design guidelines and audit checklist for the physical environment, including signage, on pages 95-110.
47. [The Center for Health Design's Designing for Age - Related Changes Among Older Adults \(PDF\)](#) Summarizes common changes that occur with aging and offers design strategies that can help older adults maximize independence.
48. [Fraser Health's Code Plus Physical Design Components for an Elder Friendly Hospital \(PDF\)](#) Guidelines for the physical design in hospitals which focus on preserving functional ability and safety of older adults admitted to hospital. Many of the design principles can be applied to other healthcare organizations.



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