

A Summary of Senior Friendly Care in Central LHIN Hospitals

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



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1. Executive Summary

In the summer of 2010, the Toronto Central Local Health Integration Network (TC LHIN) assembled a Senior Friendly Hospital Strategy Task Group to provide guiding steps toward the improvement of seniors' health and well-being by reducing their functional decline in hospitals. The efforts of this task group laid the groundwork for the Ontario Senior Friendly Hospital Strategy, and resulted in a summary report of senior friendly hospital care in the TC LHIN.¹ The report identified common themes, promising practices, and areas for improvement at the hospital and system level.

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

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

Given that seniors receive care in virtually every area of the hospital, it is critical that continuous quality improvement plans include a comprehensive, coordinated approach to protecting and responding to the needs of a growing and increasingly diverse seniors' population.

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

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

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

¹ The Regional Geriatric Program of Toronto (2010). *A Summary of Senior Friendly Care in Toronto Central LHIN Hospitals*. Toronto: Toronto Central Local Health Integration Network.

The Regional Geriatric Program (RGP) of Toronto produced a background document titled *Senior Friendly Care in Toronto Central LHIN Hospitals*² as well as an accompanying *Self-assessment Template*. The latter document was subsequently modified and both were distributed by the LHINs to their member hospital organizations. The documents were based on the RGPs of Ontario-endorsed Senior Friendly Hospital Framework, which is composed of five interrelated domains: organizational support, process of care, emotional and behavioural environment, ethics in clinical care and research, and physical environment.

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

Seniors utilize a significant portion of hospital resources in the Central LHIN. The LHIN's hospital organizations report, on average, that 55% of their total hospital days are attributable to older patients. Moreover, they report that an average 89% of alternate level of care (ALC) days are attributable to seniors. A substantial body of evidence shows that the hospital stay itself puts seniors at risk for complications and loss of functional ability, thereby contributing to longer lengths of stay and ALC. It has been estimated that one-third of frail seniors lose independent function as a result of hospital practices, half of whom are unable to recover the function they lost.^{3,4}

The Ontario Senior Friendly Hospital Strategy is designed to inform hospitals' senior leaders about how to modify the organization and provision of care to older patients. Additionally, it is intended to emphasize the multiple dimensions of organizational change that are needed to improve health outcomes for seniors. In the next steps of the provincial strategy, an Ontario-wide survey of leading practices, tied to best evidence on senior friendly hospital care, will guide the province and the LHINs in identifying specific areas of focus for improvement. The provincial report will also guide a task group assigned with the development of indicators to track improvements in senior friendly hospital care within the LHINs and across the province. The Central LHIN will support its hospital organizations in adopting the Senior Friendly Hospital Framework and integrating measurable objectives into hospital service accountability agreements. This continuing work also provides concrete opportunities for hospitals to achieve their commitments within other overarching quality

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

³ Covinsky KE, RM Palmer, RH Fortinsky, SR Counsell, AL Stewart, D Kresevic, CJ Burant, and CS Landefeld (2003). Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age. *Journal of the American Geriatrics Society* 51(4): 451-458.

⁴ Sager MA, T Franke, SK Inouye, CS Landefeld, TM Morgan, MA Rudberg, H Sebens, and CH Winograd (1996). Functional outcomes of acute medical illness and hospitalization in older persons. *Archives of Internal Medicine* 156(6): 645-652.

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

Results from the Central LHIN hospital self assessments reflect the degree to which senior friendly care is prioritized by its hospital organizations. Five hospital organizations in the LHIN have designated a senior executive lead to support care of the elderly initiatives, three express commitments to become senior friendly hospitals, and two have explicit goals for senior friendly care within their strategic plans. A number of educational initiatives support the development of frailty-focused skills in organizations' human resources. These educational initiatives include selected senior friendly learning goals built into orientation programs for all staff, and a more comprehensive elder friendly training curriculum provided to cohorts of staff. Five Central LHIN organizations described committee structures designed to support enhanced care for the elderly. Many of these committees include patients, families, and community health service partners within their membership. Organizational leadership and commitment to develop human resource skills in geriatrics and to engage community partners in health service planning are positive steps toward improved system integration that will better serve seniors and other frail populations.

The self-assessment analysis also examined clinical processes of care that are particularly relevant to seniors admitted to hospital. Falls, pressure ulcers, adverse drug reactions, and pain management are the clinical areas that were most often reported to have developed protocols and/or formal monitoring. In contrast, continence, prevention of deconditioning, hydration/nutrition, sleep management, elder abuse, and the management of dementia-related behaviours were the clinical areas least often managed with protocols or monitoring procedures. Education and practice that emphasize inter-professional teamwork and shared responsibility for functional outcomes in older patients are important to include in ongoing hospital plans. Hospitals also reported creative partnerships and inter-organizational collaboration in many promising practices. These practices were important to support discharges from hospital and also to facilitate the expansion of practice and specialized knowledge into the community, helping to prevent avoidable admissions. Teamwork and partnership will be important enduring enablers required to support continuity in the health care system as a whole.

The hospital care experience is influenced by the emotional and behavioural climate of the organization. All hospitals indicated their support for patient-centred care and patient diversity. Some promising practices identified in this analysis include: communication boards and team rounds at the bedside that promote patient and family engagement, a Diversity and Inclusivity Committee that engages the community, and a Language Community Advisory Panel to develop communication, language, and interpretation services. It is important that these types of practices are designed and delivered in a manner that takes into account the unique needs of frail seniors, such as sensory and communication difficulties.

Central LHIN hospitals describe appropriate resources in place to address ethical challenges that arise during the provision of care. All organizations have an ethicist on staff to provide leadership and assistance in addressing challenging ethical situations. One organization describes a recently created

End-of-Life Committee, whose purpose is to develop procedures that will guide end-of-life discussions with patients and families. Regular educational resources, including formal education sessions, case study presentations, and an ethics framework and consultation algorithm, acknowledge the importance of ensuring that staff members are appropriately informed and supported to recognize and respond to unique ethical situations as they arise in practice.

Aspects of the physical environment were cited by all Central LHIN hospital organizations as creating barriers to providing senior friendly care. Many hospitals rely on building code standards and accessibility legislation to guide design and development of physical structures. There is a significant body of information regarding senior friendly environmental design^{5,6} with principles that go beyond generalized building code requirements or disability legislation outlined in the Accessibility for Ontarians with Disabilities Act (AODA). Three organizations have conducted audits of their physical spaces utilizing senior friendly resources, resulting in the implementation of design and equipment features to promote enhanced safety and comfort for older patients and visitors. An organization that is planning a redevelopment project has indicated the intention to utilize senior friendly design resources in the design and implementation of its new facility. Since building improvements are long-term and costly undertakings, teams involved in developing, purchasing, and maintaining the physical facility should be informed on senior friendly design to promote the ongoing development of physical environments that meet the needs of seniors and other frail populations. This, in turn, will result in improved patient safety, comfort, and independence. If well implemented, redevelopment projects may also bring about work design efficiencies that allow staff to dedicate more time to direct patient care.

The current state of senior friendly hospital care in the Central LHIN includes many promising practices as well as important opportunities for improvement. Hospitals in the LHIN identified the importance of health equity, patient-centred care, safety, medical ethics, and accessibility. These foundational principles have been present in hospitals for many years, often implemented in response to accreditation standards and, in the case of accessibility, through legislation. There is an opportunity to translate these core principles into specific strategies to more fully meet the needs of frail seniors. Identifying senior friendly care indicators will provide feedback to guide the development and continued refinement of care and service across the system. Teamwork and partnerships were frequently highlighted as enablers of success, and will serve to enhance system integration and performance. Another key to achieving senior friendly care is the facilitation of knowledge sharing opportunities, so that hospitals across the Central LHIN – and across the province – can learn from one another and work collaboratively to improve the quality of care for seniors across the hospital system.

⁵ Parke B, and K Friesen (2008). *Code Plus: Physical Design Elements for an Elder Friendly Hospital*. Fraser Health Authority

⁶ Frank C, J Hoffman, and D Dickey (2007). Development and Use of a Senior Friendly Hospital Environmental Audit Tool. *Canadian Journal of Geriatrics* 10(2): 44-52.

2. The Ontario Senior Friendly Hospital Strategy in the Central LHIN

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

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

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

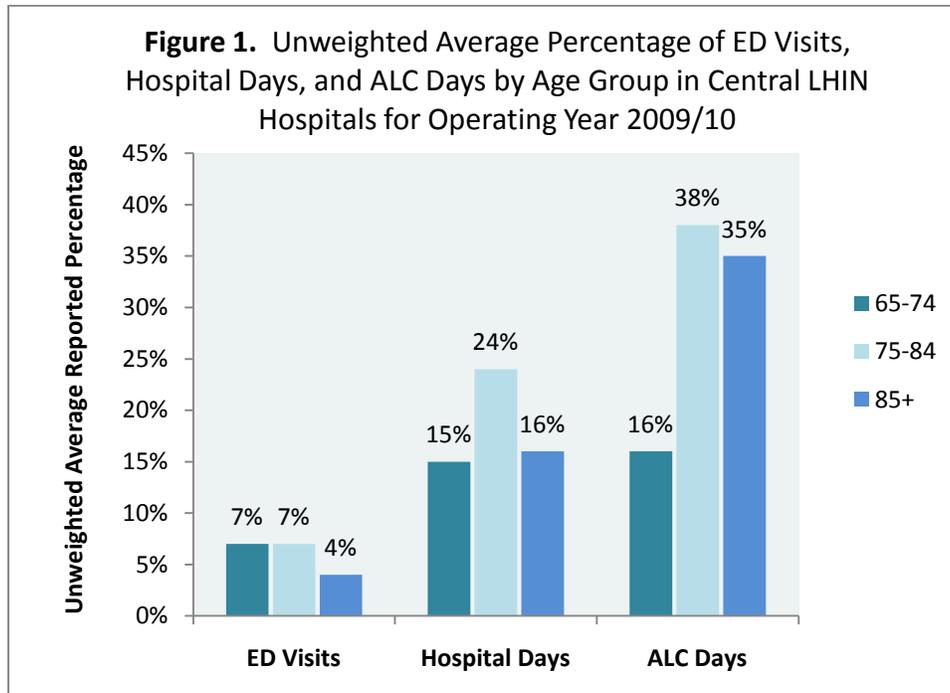
2.2 THE SENIOR FRIENDLY HOSPITAL STRATEGY IN THE CENTRAL LHIN

The Central LHIN has a rapidly growing and aging population. At present, its proportion of older adults is below the provincial average. However, recent projections predict that between 2008 and 2018, the population of seniors in the Central LHIN will have the third highest growth rate in the province. By 2018, the total population over 65 in the Central LHIN will be the highest in Ontario. In particular, the population cohort of age 85 or older is predicted to grow by 43% between 2008 and 2018, and it is expected to have a significant impact on health service delivery in the region.⁷ Central

⁷ KPMG (2008). *Central LHIN Health Service Needs Assessment and Gap Analysis*. Retrieved at [http://www.centrollhin.on.ca/uploadedFiles/Public_Community/SNAGA/AppendixN-SeniorsServices\(1\).pdf](http://www.centrollhin.on.ca/uploadedFiles/Public_Community/SNAGA/AppendixN-SeniorsServices(1).pdf)

LHIN providers identify seniors' services as a priority, providing ample rationale for making the Senior Friendly Hospital Strategy a priority to support healthy communities in the LHIN's geographic region.

A 2007-2008 profile of Aging in Ontario⁸ estimated that 14.7% of Central LHIN's population is comprised of older adults above age 65. This age cohort accounts for a significant proportion of hospital system usage in the LHIN. Hospital organizations across the LHIN report, on average, that 18% of ED visits, 55% of total hospital days, and 89% of ALC days are attributed to older adults (Figure 1). Considering the projected growth rate of the seniors' population in the Central LHIN, the pressures that exist now in managing hospital length of stay and ALC rates will increase significantly unless mitigating strategies are implemented.



* data for the Complex Continuing Care service at one hospital site were not included in these results

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

⁸ Institute for Clinical Evaluative Sciences (2010). *Aging in Ontario: An ICES Chartbook of Health Service Use by Older Adults*. Toronto: Institute for Clinical Evaluative Sciences.

3. Conceptual Underpinning – The Senior Friendly Hospital Framework

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

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

- 1) **Organizational Support** – There is leadership and support in place to make senior friendly care an organizational priority. When hospital leadership is committed to senior friendly care, it empowers the development of human resources, policies and procedures, care-giving processes, and physical spaces that are sensitive to the needs of frail patients.
- 2) **Processes of Care** – The provision of hospital care is founded on evidence and best practices that acknowledge the physiology, pathology, and social science of aging and frailty. Care is delivered in a manner that ensures continuity within the health care system and with the community, so that the independence of seniors is preserved.
- 3) **Emotional and Behavioural Environment** – The hospital delivers care and service in a manner that is free of ageism and respects the unique needs of patients and their caregivers, thereby maximizing satisfaction and the quality of the hospital experience.
- 4) **Ethics in Clinical Care and Research** – Care provision and research are conducted in a hospital environment that possesses the resources and capacity to address unique ethical situations as they arise, thereby protecting the autonomy of patients and the interests of the most vulnerable.
- 5) **Physical Environment** – The hospital's structures, spaces, equipment, and facilities provide an environment that minimizes the vulnerabilities of frail patients, thereby promoting safety, independence, and functional well-being.

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

4. RGP Background Document and Self-assessment Process

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

5. Goals of the Self-assessment Summary

The self-assessment summary report aims to:

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

6. Methods

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

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

Hospital responses were examined for common themes and innovative practices and, where appropriate, they were aggregated to provide a system-based view. Like the self-assessment

template, the analysis was shaped around the Senior Friendly Hospital Framework, which provided a structured basis for the identification of common areas of focus, strengths, and opportunities for improvement.

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

Figure 2. Hospital Organizations in the Central LHIN

Hospital	Inpatient Services Provided			
	Acute Care	Mental Health	Rehabilitation	Complex Continuing Care
Humber River Regional Hospital Church Site Finch Site Keele Site	✓	✓	✓	
Markham Stouffville Hospital Markham Stouffville Hospital Site Uxbridge Cottage Hospital Site	✓ ✓	✓	✓	✓ ✓
North York General Hospital North York General Hospital Site Branson Site (Ambulatory and Urgent Care Clinics)	✓	✓		
Southlake Regional Health Centre	✓	✓	✓	✓
Stevenson Memorial Hospital	✓			
York Central Hospital	✓	✓	✓	✓
St. John’s Rehabilitation Hospital			✓	

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

7. Limitations of the Analysis

It is important to acknowledge the limitations of the current analysis of senior friendly hospital care in the Central LHIN. Hospital organizations varied in their resources, data collecting infrastructure, reporting methodology, and ultimately in the ease with which they were able to retrieve and report the data requested in the self-assessment. This resulted in variations in the quality and consistency of information, particularly the numerical data that was returned for analysis. Self assessment methodology has proven to be helpful in determining training, self-improvement, and coaching needs. However, as with all data collection, care must be taken to ensure that information is accurate and credible. The exploratory nature of this report meant that both quantitative and qualitative data demanded a degree of subjective interpretation requiring clinical and contextual familiarity with the health system and the types of services discussed in the reports. Multiple clinical

reviewers helped to minimize the effect of this limitation and consensus amongst the reviewers was reached without difficulty. Finally, the self-assessment template was not developed to perform a detailed environmental scan; therefore, this report is not intended to be a comprehensive comparison of all Central LHIN hospital services for seniors. For instance, in highlighting their successes, organizations may not have included all relevant activities, meaning that there are likely unreported services and activities worthy of mention.

8. Findings

8.1 ORGANIZATIONAL SUPPORT

There is a growing commitment toward Senior Friendly Care by hospital organizations in the Central LHIN. Five of the seven organizations have designated a senior executive lead for geriatrics-related activities, and four have formed designated committees to guide planning in Senior Friendly care. These are positive first steps in establishing leadership and planning structures that will empower improved care and service for frail older patients. A smaller proportion of the Central LHIN’s hospitals have made the broader commitment to move toward becoming Senior Friendly organizations. Three Central LHIN hospitals have explicit commitments by their board of directors to work toward becoming Senior Friendly. In two of these organizations, there are concrete goals for Senior Friendly care within their strategic plans.

Figure 3. Organizational Support Questions

Query	Hospitals with “Yes” Response
Does your hospital organization have an explicit priority for senior friendly care in its strategic plan?	2 of 7
Has the Board of Directors made an explicit commitment to become a senior friendly hospital organization?	3 of 7
Has a senior executive been designated as the organizational lead for geriatric/care of the elderly initiatives?	5 of 7
Do you have a designated hospital committee for care of the elderly?	4 of 7

The way that an organization supports and leverages its human resources can demonstrate its commitment to meeting the complex health care needs of an older adult population. One of the ways this can be accomplished is by supporting staff members with relevant education on the clinical and service needs of older patients, helping to nurture a facility-wide senior friendly culture. Two hospitals in the Central LHIN have incorporated geriatrics learning objectives into their staff orientation programs. One such program delivers education on age-related changes in older adults, dementia, delirium, and depression; while also focusing on ways to integrate a person-centred approach with older patients. Two organizations have engaged selected staff members in a comprehensive elder friendly training curriculum. In one organization, four hundred and fifty hospital staff members were trained, while in the other, forty clinical staff were provided with this opportunity. A common theme in many Central LHIN hospitals is that clinical team members

recognized as geriatrics champions are called upon to lead periodic learning opportunities such as lunch and learn events, forums, and geriatrics rounds. As well, Geriatric Emergency Management (GEM) nurses often take on the role of educator and in-house capacity builder, although the scope of their role is largely limited to emergency departments. Older adults are patients and customers in virtually all units and services of the hospital, warranting educational initiatives that build core competencies in all hospital staff. The recognition that senior friendly practice and culture needs to be embodied throughout the entire organization, in clinical and non-clinical areas, is one that will advance an environment that is truly supportive of older adults.

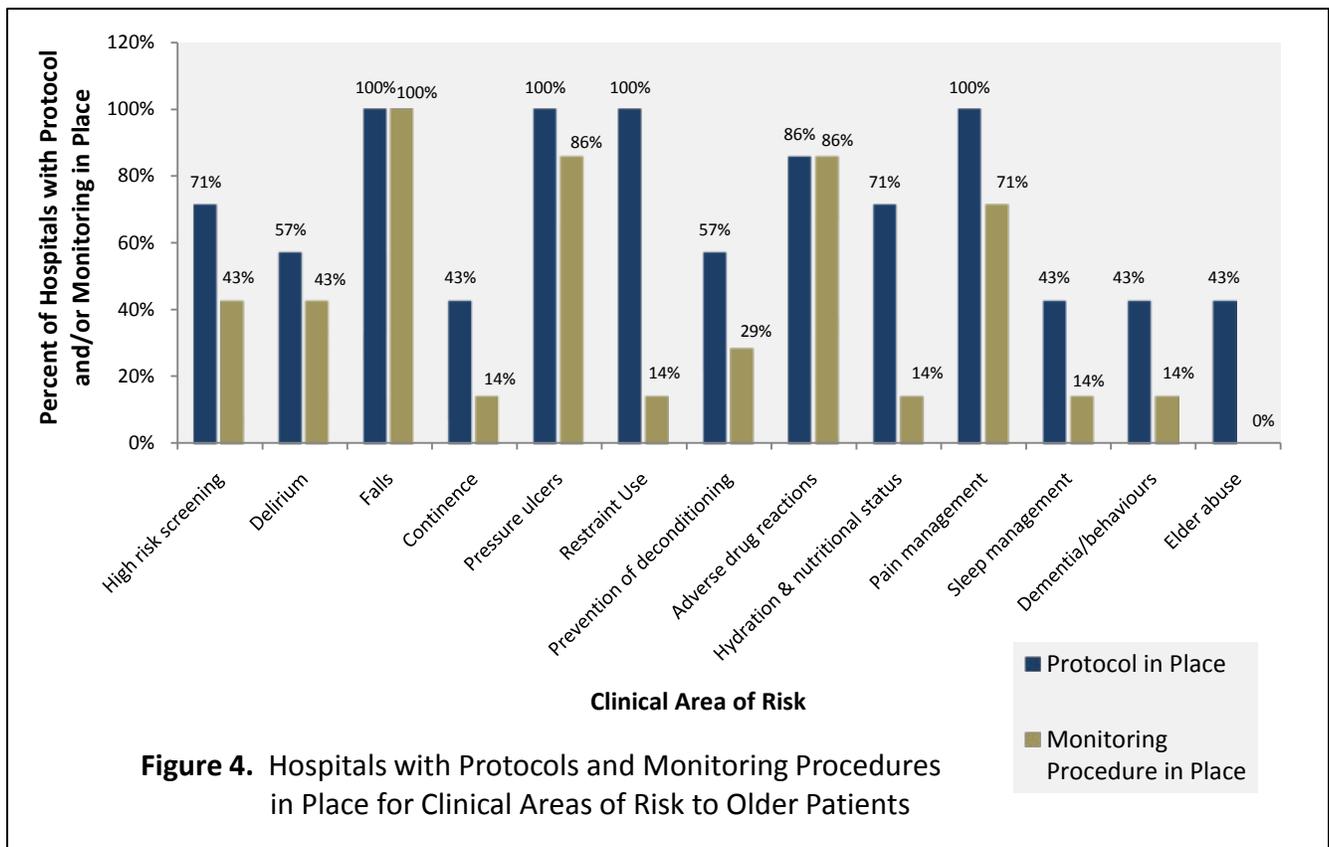
The domain of organizational support in the Senior Friendly Hospital Framework also examines formal structures in place to solicit input from patients, families, and health system partners to guide the development of hospital programs and services. These efforts often go beyond generalized patient feedback mechanisms such as satisfaction surveys and patient relations processes. One example is to have community representation on durable hospital committees tasked with planning ongoing services. Three organizations describe committee structures designed with this purpose. In one organization, a Senior Friendly Community Advisory Panel has been formed – two thirds of its membership consists of patients, family members, and community service representatives. Another hospital describes a Community Advisory Committee that includes former patients and volunteers within its membership. Two other hospitals participate in a Senior Friendly Advisory Committee which includes community partners in its membership. Other organizations in the Central LHIN facilitate periodic meetings and information-sharing events, in which they engage community partners such as long-term care homes, the Community Care Access Centre (CCAC), community service agencies, municipal governments, and local seniors groups. The needs of frail seniors are multi-dimensional and complex. Therefore, service planning that seeks broad and diverse input is best suited to guide the development of programs that meet the needs of older patients. Formal and comprehensive consultation with stakeholders and partners has the potential to improve integration and collaboration across the system as new services are developed and existing services are refined. This, in turn, may improve patient and family satisfaction with hospital services.

Organizational Support – Promising Practices in the Central LHIN

- *Support for education throughout the organization to build the capacity of its human resources to serve older adults and to foster a Senior Friendly organizational culture. Education is planned and coordinated to reach all staff.*
- *Care planning committees with comprehensive representation, including community members and health system partners, to help guide the ongoing development of seniors health services*
- *Collaborations between Central LHIN hospitals, such as a Senior Friendly Advisory Committee whose efforts are shared by two hospital organizations*

8.2 PROCESSES OF CARE

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



This observation is consistent with a recent study of geriatric ‘quality indicators’ for hospital care.⁹ One of the results of this study revealed a significantly higher rate of compliance with quality indicators for general medical care when compared with those for geriatric-specific issues. While having a protocol or monitoring procedure is only one aspect of providing care, the observations in this self-assessment analysis may identify potential care gaps for common geriatric issues arising in hospital. In the Central LHIN, an innovative protocol that has been implemented in one organization

⁹ Arora VM, M Johnson, J Olson, et al. (2007). Using Assessing Care of Vulnerable Elders Quality Indicators to Measure Quality of Hospital Care for Vulnerable Elders. *Journal of the American Geriatrics Society* 55: 1705-1711.

and planned in another is the Hospital Elder Life Program (HELP), shown in studies to improve physical function and decrease the incidence of delirium in older hospitalized patients.¹⁰

The self-assessment template also facilitated an examination of clinical metrics over three consecutive years for two indicators of care – fall rates and the acquisition of pressure ulcers. All seven hospital organizations in the Central LHIN report having protocols to manage these clinical challenges. There were some notable improvements observed, demonstrated by reductions in fall rates and pressure ulcer prevalence, although this was not consistent at all sites, services, and organizations. In some circumstances, the implementation of improved monitoring protocols may have led to higher measured and reported values and did not reflect actual increases in these adverse events. It will be important to examine the factors for success in the organizations and/or sites that are able to measure improvement in these clinical areas. Whether they reflect positive features in the care processes, systems or protocols, environment, leadership support, human resources, organizational culture, or any other variable, the transfer of this knowledge to other organizations can benefit the hospital system as a whole.

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

The self-assessment also inquired about senior friendly practices in the emergency department (ED). The capabilities of Geriatric Emergency Management (GEM) nursing staff were consistently described as being indispensable resources within emergency departments, and facilities often increased their availability to extended hours. GEM nurses screen older adults to determine those at high risk of adverse events, refer patients to appropriate services, and link with patients, families, and community partners to help facilitate complex, multi-disciplinary follow up care in the community. In addition to the GEM nurses, at least one hospital supports extended hours for social work services in

¹⁰ Inouye SK, ST Bogardus, DI Baker, L Leo-Summers, and LM Coonley (2000). The hospital elder life program: a model of care to prevent cognitive and functional decline in older hospitalized patients. *Journal of the American Geriatrics Society* 48(12): 1697-706.

the ED to help manage complex cases. Organizations also empower volunteers in the emergency department to engage older patients and assist with hydration. Hospitals also describe Nurse-Led Outreach Teams, whereby nurse specialists provide assessment and treatment services to the residents of partnered long-term care homes. Through education and capacity building, outreach nurses also help to improve the capabilities of LTC home staff so that residents can receive appropriate services at home rather than transfer to an emergency department. Several emergency departments in the Central LHIN also describe the practice of referring patients directly to geriatric assessment, falls, and stroke prevention clinics so that patients may receive appropriate services without being admitted to hospital.

Supportive transitions and discharge planning are key features of senior friendly hospital care and for this reason, hospitals were asked to report on their practices in these areas. Central LHIN organizations describe partnerships with the Home First and Home at Last programs, both of which provide additional support to discharged patients to help them transition home. Another strategy is to link patients with services in the community, such as specialized clinics or geriatric outreach teams, to provide follow-up care after hospital discharge. Hospitals also refer to the LHIN’s “Doorways to Care” program to help patients find appropriate supportive service in the community. One hospital has created a partnership with another hospital organization for an acute care transition service that assists discharged patients. Further examples of inter-organizational collaboration described by Central LHIN hospitals facilitate the provision of convalescence care in LTC, retirement homes, and hospice facilities for patients requiring additional support before transitioning home. Collaboration and partnership within the hospital and reaching outward into the community are key variables that ultimately facilitate successful patient transition strategies. Fostering skills in inter-organizational collaboration will strengthen these types of creative relationships and ultimately improve health system integration in order to help discharged seniors remain at home.

Figure 5: Senior Friendly Care Priority Initiatives

Hospitals were asked to describe their most successful Senior Friendly Care initiatives and their top priorities for ongoing development. Responses clustered into the following themes:

Implementation or Expansion of Clinical Services and Protocols:

- Implementing new programs and models of care – transitional care program, short-term reconditioning, Inter-Professional Model of Care, geriatric consultation service, Hospital Elder Life Program (HELP), Nurse Led Outreach Teams, geriatric outreach, client-centred goal planning tool
- Clinical protocols and pathways for falls, early mobilization, pressure ulcers, delirium, medication reconciliation, nutrition, high risk screening, discharge planning, elder abuse
- Developing specialized geriatric assessment clinics
- GEM program development

Hospital Strategic Planning and Leadership Committees

- Continue building Senior Friendly Advisory Committee and partnerships
- Building corporate awareness of the need for geriatrics services
- Defining and refreshing strategic directions for Senior Friendly Care
- Health equity planning

Education and Research Initiatives

- Annual Seniors’ Fair
- Cultural competency education
- Community engagement presentations
- Senior’s health research

Physical Environment Updates and Hospital Site Redevelopment

Processes of Care – Promising Practices in the Central LHIN

- *The identification of priorities in clinical practice amongst Central LHIN hospitals will be a catalyst for the development and implementation of innovative protocols and metrics, such as the Hospital Elder Life Program (HELP) to reduce delirium and early mobilization initiatives to reduce functional decline*
- *Process of care initiatives that encourage inter-professional practice*
- *Deploying volunteers in the Emergency Department to engage patients and assist in hydration may have beneficial impacts on patient safety and satisfaction*
- *The fostering of creative and effective inter-organizational partnerships to expand the reach of specialized practice and build capacity in health system partners, such as Nurse Led Outreach Teams to LTC homes*

8.3 EMOTIONAL AND BEHAVIOURAL ENVIRONMENT

The emotional and behavioural environment of a hospital generates the atmosphere in which care and service are delivered, and this domain of the Senior Friendly Hospital Framework examines efforts in patient- and family-centredness, communication, diversity, satisfaction, and respect. GEM nurses frequently act as education and resource leads for geriatrics in the emergency department to help foster a more senior friendly environment within this setting. A number of Central LHIN hospitals describe educational initiatives which reach greater numbers of staff – they include senior-specific education components in staff orientation training. In one case, education includes clinical aspects of caring for seniors as well as strategies for observing a person-centred approach with older adults. In another facility, eldercare training is provided for all new hires. Two facilities have also made one-time investments which provided comprehensive Elder Friendly training to a significant number of staff. These trained staff members can be empowered to act as geriatrics champions across the organization to help build and foster a senior friendly culture. Two organizations also describe significant education initiatives in patient-centred care – in one organization, a two-day training program is offered monthly, and in the other facility, two-day workshops built from the Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines on Person-Focused Care have been provided to 73% of staff. Examples of practices that harness patient-centred senior friendly principles include patient/family conferences, communication boards in patient rooms, and bedside team rounds to incorporate patient feedback into care planning. Hospitals in the Central LHIN also describe initiatives to provide care to diverse populations. These include communication resources such as in-person or telephone-based translation services, pocket talkers and aids for the hard-of-hearing, and multi-faith worship services. One organization has established a Diversity and Inclusivity Committee that is developing a plan to engage the community, while another describes a Language Community Advisory Panel that advises on communication, language, and interpretation services.

Emotional and Behavioural Environment – Promising Practices in the Central LHIN

- *Designing staff orientation programs that incorporate education in both clinical and non-clinical aspects of caring for seniors, including patient- and family-focused care; thus empowering an organizational culture that is friendly to seniors*
- *Communication boards and team rounds at the bedside that involve patients and families in the communication process and in care planning*
- *Committees dedicated to diversity services that engage the community and influence organizational culture and practice*

8.4 ETHICS IN CLINICAL CARE AND RESEARCH

As highlighted in the background document, complex ethical issues frequently arise when caring for older patients. It is important for hospitals to have structures in place that support practitioners in approaching these challenges thoughtfully. All hospital organizations in the Central LHIN demonstrated awareness of common challenges and the need to have processes designed to deal with ethical challenges in hospital health care encounters. All hospitals have an ethicist on staff to provide assistance in challenging clinical scenarios, and reported similar types of ethical situations related to the care of older adults emerging in practice, the most common of which are listed below:

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

Central LHIN organizations also have procedures in place to observe advance care directives – five hospitals report specific policies although their scope is generally limited to guiding resuscitation decisions. One organization has recently created an End of Life Committee for the purpose of developing policies and procedures to guide end-of-life discussions with patients and families. With respect to challenges that arise in capacity and decision making, Central LHIN hospitals describe a team approach. The expertise of on-site staff – which may include social workers, physicians, geriatric psychiatrists, occupational therapists, patient flow coordinators, CCAC case managers, ethicists, and patient relations representatives – is utilized to resolve these issues. When further intervention is required, external agencies such as the office of the Public Guardian and Trustee or the Consent and Capacity Board are consulted. With these resources and procedures in place, organizations need to ensure that all clinical staff members receive relevant and appropriate education on ethical issues, so that they continue to be aware of how to leverage these resources to

manage unique ethical situations as they arise in practice. Some ways that this is being done in the Central LHIN include formal education sessions, case study presentations, and an ethics framework and consultation algorithm.

Ethics in Clinical Care and Research – Promising Practices in the Central LHIN

- *The availability of a clinical ethicist, and regular learning opportunities so that staff are prepared to respond to unique ethical challenges when they arise in practice*
- *Developing policies and protocols to guide end-of-life discussions with patients and families*

8.5 PHYSICAL ENVIRONMENT

When asked to identify barriers to senior friendly care, all Central LHIN organizations cited aspects of their physical environment. Older hospital structures were built at a time when the majority of patients were younger and when building guidelines did not emphasize universal access. Many of the hospitals in the Central LHIN currently rely on building code requirements and on Accessibility for Ontarians with Disabilities Act (AODA) legislation when auditing and developing their physical spaces. There is a significant body of information regarding senior friendly environmental design^{11,12} and these principles go beyond generalized guidelines for disability and accessibility. Three organizations in the Central LHIN have conducted audits of their physical spaces utilizing senior friendly resources. This has resulted in the implementation of design and equipment features to promote the safety and comfort of seniors, such as matte flooring finishes, soothing artwork and décor, large clocks and calendars, phones with large keypads and volume controls, in-line amplifiers, pocket talkers, sheet magnifiers, and large print signs. A well implemented senior friendly physical environment incorporates building features that maximize safety and comfort, and engineers work design efficiencies to improve the ability of staff to monitor and interact with patients. Whether planning retrofit projects or entire site redevelopment, there are opportunities 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. The implementation of a comprehensive senior friendly physical design in a hospital organization in Victoria, British Columbia suggests that this can be a cost-neutral undertaking when appropriate clinical knowledge guides design decisions.¹³ One step that has been taken by an organization in the Central LHIN is to include seniors from their Community Advisory Panel on the hospital's accessibility committee. They will provide important input toward planned physical audits focusing on vision, hearing, and mobility; the results of which

¹¹ Parke B and K Friesen (2008). *Code Plus: Physical Design Elements for an Elder Friendly Hospital*. Fraser Health Authority

¹² Frank C, J Hoffman, and D Dickey (2007). Development and Use of a Senior Friendly Hospital Environmental Audit Tool. *Canadian Journal of Geriatrics* 10(2): 44-52.

¹³ Vancouver Island Health Authority, Personal Communication

will be used to plan for future upgrades. Capital improvement projects and significant infrastructure renewals are ongoing, long-term, and costly processes. Recognizing this, it is important that staff involved in these projects have training and access to resources on senior friendly environmental design so that the cumulative effect of physical upgrades is a senior friendly physical environment. There are opportunities for organizations to consider more comprehensive training and knowledge acquisition in senior friendly environmental design for staff involved in the development, maintenance, and purchasing operations of the physical plant.

Physical Environment – Promising Practices in the Central LHIN

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

9. Looking Ahead – Moving toward Senior Friendly Hospital Care in the Central LHIN

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

The seven hospital organizations in the Central LHIN demonstrate a growing commitment toward senior friendly care. All have clinicians who act as geriatric champions, and five organizations have designated a senior executive lead for care of the elderly priorities. Three hospitals have expressed a commitment to become senior friendly organizations, and two have articulated specific commitments within their strategic plans. Three organizations describe educational initiatives to support the capacity of their human resources to provide care and service to frail seniors. These include the incorporation of eldercare training into new staff orientation programs, and the provision of a comprehensive elder friendly training curriculum to large numbers of staff who can then be empowered to act as geriatrics champions across the organization. Soliciting community feedback toward the development of hospital programs is another way an organization can promote senior friendly care. One organization describes a Senior Friendly Community Advisory Panel where two thirds of its members are patients, family members, and community service representatives. Two other organizations partner in a Senior Friendly Advisory Committee that includes representation from community partners. Another organization seeks the input of former elderly patients and

volunteers through its Community Advisory Committee. Seeking comprehensive community consultation on service planning committees may enable better service integration across the health system and, ultimately, better health outcomes for frail seniors who frequently need to access health services from multiple sectors.

Most organizations are familiar with published best practice guidelines. For instance, all hospitals in the Central LHIN have protocols in place for falls and pressure ulcers – two areas of practice for which there are considerably well developed evidence-based guidelines. The self assessment report also identified a number of clinical areas where there has been less thorough adoption of protocols and best practice. Further opportunities exist to hone clinical practice in the areas of continence, prevention of deconditioning, hydration/nutrition, sleep management, elder abuse, and the management of dementia-related behaviours. Two well studied models of hospital practice, for which positive outcomes have been reported, are the Acute Care for Elders (ACE) unit¹⁴ and the Hospital Elder Life Program (HELP).¹⁵ A key variable measured in both of these models was the degree to which functional decline of patients could be prevented as a result of the intervention. Functional decline can directly impact the ability of frail patients to return home and this has a secondary but far-reaching effect on the health system, evident in emergency room congestion and ALC rates. Given the level of impact on the patient and the health system, it is worthwhile to consider the implementation of clinical programs focused on the prevention of functional decline and, once in place, evaluate their impact on patient outcome and satisfaction. One organization in the Central LHIN has implemented the HELP program and another is in the planning stages. Both organizations envision the expansion of this initiative across their facilities. In addition, two organizations have concrete goals to implement early mobilization protocols. As improved outcomes are realized, it will be worthwhile to consider broader implementation of these programs and protocols across the LHIN.

Organizations in the Central LHIN identified practices that address diversity, patient-centred care, safety, medical ethics, and physical accessibility. These foundational principles have been present in hospitals for many years, often implemented in response to accreditation standards and, in the case of accessibility, through building code and disability legislation. These generalized guidelines, however, do not often go far enough to fully meet the needs of frail seniors. Two organizations analyze patient satisfaction results based on age cohort populations, and a third is in the process of implementing this process. This may help to inform decisions on quality improvement initiatives that will better account for the specific needs of seniors. The use of senior friendly design resources in physical infrastructure planning and development is another opportunity to address the needs of

¹⁴ Landefeld CS, RM Palmer, DM Kresevic, RH Fortinsky and J. Kowal (1995). A randomized trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. *New England Journal of Medicine* 332: 1338-44.

¹⁵ Inouye SK, ST Bogardus, DI Baker, L Leo-Summers, and LM Coonley (2000). The hospital elder life program: a model of care to prevent cognitive and functional decline in older hospitalized patients. *Journal of the American Geriatrics Society* 48(12): 1697-706.

vulnerable seniors. These design principles incorporate measures that assist with vision, communication, cognitive, and dexterity barriers. When senior friendly principles are applied to some of the hospitals' ongoing foundational activities in health equity, patient- and family-centred care, patient safety, medical ethics, and physical accessibility, care for seniors and other vulnerable populations will be enhanced.

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

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

Organizations in the Central LHIN cited limitations in financial resources as a barrier to the broad execution of senior friendly activities. A commitment to allocate resources to implement programs that enhance organizational culture, operationalize evidence-based protocols, and improve physical spaces is an investment that will realize improved patient safety and staff productivity. It will be an ongoing challenge for organizations to find cost-effective solutions to progress toward a senior friendly state. Working toward the physical environment component of a senior friendly hospital, for example, is an area where enhanced knowledge acquisition can realize cost efficiencies. By referencing senior friendly design resources, new capital, building, and renovation expenditures can move an organization toward a senior friendly physical environment over time by ensuring that regular procurement and design decisions consider the needs of seniors. The case for "spending well" rather than "spending more" is well justified when the return on investment is the creation of a

physical hospital environment that not only accommodates the needs of seniors, but also supports patients and visitors of all ages and disability levels. Knowledge sharing between organizations will be another important process to continue empowering the adoption of successful practices. Innovative and cost-effective delivery of system-wide, frailty-focused education adds enduring value by breaking down attitude and culture barriers, whilst improving the tools and skills of hospital employees to better serve frail seniors. Additionally, improved inter-professional collaboration and greater confidence in building effective cross-sector partnerships will foster innovation and may even reveal unexpected efficiencies in the health system. It is recognized that resources vary from organization to organization and that changes in accountabilities relating to senior friendly care may need to be phased in over a practical timeframe. These changes, however, will improve the quality of care and health outcomes, and also lower costs to hospitals and the health system by reducing errors and adverse events, with the potential co-occurring benefit of lowering wait times and ALC days.

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

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

10. Highlights of Innovative Practices across the Central LHIN

ORGANIZATIONAL SUPPORT

Support for Education to Foster a Senior Friendly Organizational Culture

- *Annual Seniors' Fair (Markham Stouffville Hospital, Southlake Regional Health Centre, York Central Hospital)* – promoting education, awareness and relationship building between staff, volunteers, visitors, and community service partners
- *Elder Friendly Training (North York General Hospital, St. John's Rehabilitation Hospital)* – large cohorts of staff participated in training sessions, empowering geriatrics champions across the organization
- *Geriatrics Education in Orientation of New Staff (North York General Hospital, York Central Hospital)* – learning goals include clinical topics and ways to integrate person-centred approaches when caring for the elderly

Collaborative Service Planning Committees

- *Community Advisory Committee (St. John's Rehabilitation Hospital)* – a committee which includes former elderly patients and volunteers
- *Senior Friendly Advisory Committee (Southlake Regional Health Centre, Stevenson Memorial Hospital)* – a partnership between two hospital organizations to develop a shared Senior Friendly Framework
- *Senior Friendly Community Advisory Panel (York Central Hospital)* – a committee involved in geriatrics focused service planning for the hospital; two thirds of membership consists of patients, families
- *Collaboration with Town Committees (Markham Stouffville Hospital)* – working with the Town of Markham and local seniors' groups to develop seniors' programming at a local community centre

PROCESSES OF CARE

Specialized Services and Programs

- *Hospital Elder Life Program (York Central Hospital)* – a program that leverages volunteers to engage older inpatients with the aim of reducing delirium and functional decline in hospital
- *Short-Term Active Reconditioning (STAR) Program (St. John's Rehabilitation Hospital)* – provides active rehabilitation for patients with multiple conditions who are deconditioned from a long hospital stay
- *Transitional Care Program (Markham Stouffville Hospital)* – an inter-professional team provides restoration and reactivation activities to optimize functional status of patients and avoid LTC admissions
- *Transitional Care Unit (Southlake Regional Health Centre)* – provides additional recreation therapy services to patients designated as ALC

Clinical Care Protocols and Pathways

- *Inter-Professional Model of Care for the Medical System (Markham Stouffville Hospital)* – the patient care team works together through intensive case management and targeted interventions to improve patient flow

- *Pressure Ulcer Prevention and Falls and Least Restraint Programs (Humber River Regional Hospital)* – rigorous monitoring and data collection, and risk identification that begins in the ED and is maintained across patient transitions through the hospital, returning improved outcomes
- *SPPICES High Risk Screening Tool (North York General Hospital)* – clinical staff on medical and surgical units throughout the hospital are educated on the use of this high risk screening tool and implement appropriate interventions

Creative Partnerships to Improve Health System Integration

- *Acute Care and Transition Program Partnership (North York General Hospital and Baycrest)* – a partnership whereby patients not requiring an acute care admission are referred to an assessment service at Baycrest, an organization within the Toronto Central LHIN
- *Nurse Led Outreach Teams (Humber River Regional Hospital, Markham Stouffville Hospital, Southlake Regional Health Centre, York Central Hospital)* – an initiative linking LTC facilities with nurse practitioner support to provide outreach assessment, build capacity within the homes, and avert unnecessary ED transfers
- *Pre-Discharge Home Assessments with CCAC (St. John’s Rehabilitation Hospital)* – building health system continuity by performing home safety assessments in partnership with the CCAC
- *Respite Care Partnerships (Southlake Regional Health Centre, Stevenson Memorial Hospital, York Central Hospital)* – partnerships with local retirement homes for respite care beds to provide appropriate transitional care

EMOTIONAL AND BEHAVIOURAL ENVIRONMENT

- *Bedside Rehabilitation Rounds (York Central Hospital)* – involves patients directly in care and discharge planning
- *Diversity and Inclusivity Committee (Southlake Regional Health Centre)* – supports diversity and language services, with plans to engage the community
- *Patient Communication Boards (St. John’s Rehabilitation Hospital, York Central Hospital)* – help involve the patient in care and service provision
- *Patient-Centred Care Workshops (Southlake Regional Health Centre, Stevenson Memorial Hospital, York Central Hospital)* – provide more comprehensive training and reflection for staff and volunteers to improve the hospital experience for patients
- *Participation in a Chinese Seniors’ Health Fair (Markham Stouffville Hospital)*

ETHICS IN CLINICAL CARE AND RESEARCH

- *End of Life Committee (Humber River Regional Hospital)* – developing formal policies and processes to guide end-of-life discussions with patients and families

PHYSICAL ENVIRONMENT

- *Community Seniors on Accessibility Committee (York Central Hospital)* – provide input focusing on mobility, vision, and hearing
- *Senior Friendly Environmental Audits (North York General Hospital, York Central Hospital, St. John’s Rehabilitation Hospital)* – recommendations have included the implementation of design and equipment features to promote the safety, comfort and function of elderly patients

- *Use of Senior Friendly Physical Design Guidelines in Upcoming Redevelopment Projects (Humber River Regional Hospital)* – the ongoing use of senior friendly guidelines is encouraged to optimize the environment for frail patients

Appendix 1: Self Assessment Aggregate Responses

Self-Assessment Question	Aggregate Response (Percent of Hospitals Responding “Yes”)
A1. Does your hospital have an explicit priority or goal for senior friendly care in its strategic plan?	29%
B3. Do you have clinical staff whom are formally recognized as geriatric champions within your hospital?	100%
C1.1. Has the Board of Directors made an explicit commitment to become a Senior Friendly Hospital?	43%
C1.2. Has a senior executive been designated as the organizational lead for geriatric/care of the elderly initiatives?	71%
C1.4. Do you have a designated hospital committee for care of the elderly?	57%
C1.5. Does your hospital monitor age-specific indicators of utilization and quality of care relevant to seniors at regular intervals?	86%
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?	55% penetration of protocols and metrics for listed clinical areas of risk
C2.7. Does your hospital offer any specialized geriatric services for older patients?	86%
C3.1. Do your staff orientation and education programs have defined learning objectives for senior care?	29%
C3.2. Are age-sensitive patient satisfaction measures incorporated into hospital quality management strategies?	29% (43% including those in progress)
C3.3. What formal programs and processes do you have in place to help older patients feel informed and involved about decisions affecting their care?	57% (100% including those with generalized programs for all ages)
C3.4. What programs and processes do you have in place to support diversity among seniors and their families?	0% (100% have generalized programs for all ages)
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?	57% (86% including those with generalized programs for all ages)
C4.1. Does your staff have access to an ethicist to advise on ethical issues related to care of older patients?	100%
C4.2. Does your hospital have a specific policy on Advance Care Directives?	71%
C5.1. Has your hospital conducted any senior friendly environmental audits of physical space using peer-reviewed guidelines?	43%

Appendix 2: Suggested SFH Indicators by Central LHIN Hospitals

System Utility	Safety
<ul style="list-style-type: none"> • Re-admission rates <ul style="list-style-type: none"> ○ readmission rates from LTC facilities to track for trends for improvement at the LTC facilities • Length of stay • ER utilization and admission and disposition for over 75 years • % discharge home (or previous living environment) from hospital • Activity volumes for geriatric services 	<ul style="list-style-type: none"> • Pressure ulcers <ul style="list-style-type: none"> ○ Percentage of hospital acquired pressure ulcers ○ Wound prevalence • Falls rate <ul style="list-style-type: none"> ○ Using the Risk Assessment Falls Tool (RAFT), assessed for falls risk on admission and reassessed using the same tool post any fall • Mortality • Complex Continuing Care indicators from MDS RAI concentrating on incontinence without toileting plan, catheter use • Bedfast residents with little or no activity
Satisfaction	Quality
<ul style="list-style-type: none"> • Medicine Program-Post-Discharge Follow-up Telephone Record: <ul style="list-style-type: none"> ○ Emotional Support: Did care provider introduce themselves? Explain tests and procedures to you? Do you have questions about your discharge plan, including your medication? ○ Quality and Safety: Are you confident in the care provided by your health care team? Is there anyone in particular you would like us to recognize for the care they provided? We are always looking to improve. Do you have any suggestions regarding what we can do better? 	<ul style="list-style-type: none"> • Hospital Elder Life Program – protocol utilization, volumes, discharge destination, LOS with the program • SFH domains <ul style="list-style-type: none"> ○ description of and the number of senior friendly education initiatives delivered per year/number of staff attended ○ description of and number of senior friendly physical environment standards met by each hospital/initiatives implemented ○ description of and number of senior friendly processes of care implemented in each hospital ○ Reporting of a Seniors Friendly annual work plans