Senior Friendly Hospitals: A Provincial Strategy & Let’s MOVE ON
Geriatrics Refresher Day
Ottawa
March 21, 2012

Barbara Liu, MD, FRCPC
Executive Director
Outline

- The challenge for hospitals
- A SFH framework
- The provincial senior friendly hospital strategy
  - Results to date
  - Next steps
  - Alignment
RGP Senior Friendly Hospital Framework

Processes of Care

Emotional & Behavioural Environment

Ethics in Clinical Care & Research

Organizational Support

Physical Environment

What we do

How

Who

Why

Where
Senior Friendly Hospital Provincial Strategy

**Objective**
• Identify current state

**Plan**
• Hospital self-Assessment
• LHIN-level roll-up
• Provincial roll-up

**Objective**
• Close the gap

**Plan**
• Implement hospital improvement plans
• Develop key enablers

**Objective**
• Monitor and sustain hospital and system improvements

**Future State**
• Prevent functional decline
• Improve patient experience
• Enable hospital staff
• Improve equity
Senior Friendly Hospital Care in the TC LHIN

TCLHIN Integrated Health Services Plan 2010-2013

SFH Background document and Hospital Self Assessment

TCLHIN Summary report Dec 2010

Self-Assessment Template: Senior Friendly Care in Toronto Central LHIN Hospitals

July 9, 2010

Background Document: Senior Friendly Care in Toronto Central LHIN Hospitals

July 9, 2010
Senior Friendly Hospital Care in Ontario

• Senior Friendly Hospital self-assessments completed by 155 hospitals in Ontario

• 6 RGPs of Ontario worked with 13 LHINs to generate regional SFH summary reports

• Coordination by TCLHIN and RGP of Toronto
• Describes existing state of SFH care in Ontario
• Identifies promising practices
• Recommends priority areas for action
Organizational Support

- **Hospital Leadership**
  - 56% of hospitals designated a senior executive to lead SFH
  - 39% had SFH goals in strategic plan
  - 30% had explicit commitment at level of board of directors

- **Supporting Human Resources Development**
  - 55% had geriatrics content in orientation or education for staff
  - Frailty focused education to all staff
  - Developing geriatrics champions
  - HR policies that encourage skills development in geriatrics

- **Service Planning Structures**
  - Solicit input from community and health system partners
Processes of Care

Clinical Protocols/Monitoring
- most common – falls, pressure ulcers, restraint use, pain management
- least common – management of behaviours, sleep, functional decline, hydration/nutrition
- functional decline an emerging priority

Interprofessional Practice in the Hospital
☆ geriatric assessment teams, leveraging volunteers

Inter-organizational Collaboration for Transitions in Care
☆ post D/C follow-up care
☆ partnerships for transitional care
Supporting Communication and Patient Involvement in Care

- hearing amplifiers, translation services
- team rounds at the bedside
- Early goal setting discussions
- discharge planning information packages
Ethics in Clinical Care and Research

Access to a Clinical Ethicist for Complex Situations
• 83% of hospitals have access to a bioethicist
☆ regular learning opportunities (case studies, lunch and learns)

Procedures for Capacity and Consent Issues
☆ internal processes involving appropriate clinical staff
☆ consultation with external bodies

Procedures for Advance Directives
• 78% of hospitals have formal policies/procedures, but many are limited in scope to resuscitation orders
☆ resources provided to patients, families and care team to guide advance care directives
Physical Environment

- 34% of hospitals have performed SFH audits to prioritize improvements to physical spaces
- Overall reliance on AODA and building code standards in physical planning
- Involvement of clinical staff and older adults in physical environment planning to inform design team
Provincial SFH Action Priorities

- **Functional Decline**
  - Implement interprofessional early mobilization protocols across hospital departments to optimize physical function

- **Delirium**
  - Implement interprofessional delirium screening, prevention, and management protocols across hospital departments to optimize cognitive function

- **Transitions In Care**
  - Implement practices and developing partnerships that promote interorganizational collaboration with community and post-acute services
**Priority #1 – Functional Decline**

**Screen**
Screening of older patients early in admission for risk of functional decline

**Manage**
Implementation of evidence-based protocol adapted for local context
(see Appendix A for examples of implemented practices)

**Monitor/Evaluate**
Comply with hospital indicators defined by Ontario Senior Friendly Hospital Strategy
Regular review and reporting to quality and safety committees

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**Senior Friendly Hospital Framework Recommendations – Activities to Support Priority Area**

**Organizational Support**

1. **Board of Director Commitment**
   - Senior executive lead reports to board
   - Senior executive leads working group responsible for implementing mobility program
   - Representation on quality and safety committee

2. **Senior Executive Lead**
   - Geriatrics Champions
     - Serve as peer-to-peer resource and coach in support of mobility protocols
     - Reinforce formal knowledge-to-practice activities

3. **Geriatrics Champions**
   - HR Development
     - Formal education on mobility protocols

**Emotional & Behavioural Environment**

4. **Seniors Sensitivity Training**
   - Orientation and refresher sensitivity training for all staff, clinical and non-clinical, on aging, person-focused care, and cultural competency integrated with performance appraisal processes

5. **Senior Friendly Person-Centred and Diversity Practices**

**Ethics in Clinical Care and Research**

6. **Ethicist Services Available**
   - Ensure the availability of ethicist or ethics committee to assist clinical teams, patients, and families in complex decision making

7. **Policies for Autonomy and Consent/Capacity**

**Physical Environment**

8. **Senior Friendly Design Resources Used in Addition to Accessibility**
   - Review ward set up to allow for mobilization
   - Implement environmental changes to reduce risk of falls
Senior Friendly Hospital Provincial Strategy

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**Objective**
- Close the gap

**Plan**
- Implement hospital improvement plans
- Develop key enablers
Toolkit Working Group

- Dr. Barbara Liu (Co-Chair), RGP Toronto
- Dr. Gary Naglie (Co-Chair), Baycrest Centre
- Ken Wong, RGP Toronto
- Dr. John Puxty, RGP SE ON
- David Jewell, RGP Central ON
- Anne Stephens, TC CCAC
- Sharlene Kuzik, NW LHIN
- Linette Perry, Stevenson Memorial Hospital
- Maria Boyes, Cambridge Memorial Hospital
- Susan Franchi, St. Joseph’s Care Group
- Karyn Popovich, North York General Hospital
- Dr. Monidipa Dasgupta, St Joseph’s Health Care (London)
- Bruce Viella, NE LHIN
- Susan Bisaillon, Trillium Health Centre
- Emily Christoffersen, Hamilton Health Sciences
Toolkit Development Process

- Literature review
- Tools shortlisted
- Voting on
  - Feasibility
  - Interprofessional usability
  - Need for additional resources/training
  - contributes to enhanced care
- 499 responses on 34 tools from 25 people
- Structure
  - Description, definition, rationale
  - Recommendations from provincial summary report
  - Screening and detection – tools
  - Prevention and management – guidelines, review articles, other
  - Knowledge exchange portal
SFH Toolkit Home Page

- Located within “Senior Friendly Hospitals” tab – access to other tabs provides a handy link to related RGP resources
- direct navigation also via [www.seniorfriendlyhospitals.ca](http://www.seniorfriendlyhospitals.ca)
## Tools

Clicking on the tool link opens a summary page containing practical information on use of the tool, instructions and sourcing information.

### Tools for the Screening and Assessment of Delirium

<table>
<thead>
<tr>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion Assessment Method (CAM)</td>
</tr>
<tr>
<td>Delirium Observation Screening Scale (DOSS)</td>
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<tr>
<td>CAM-ICU</td>
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<tr>
<td>Intensive Care Delirium Screening Checklist (ICDSC)</td>
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</tbody>
</table>

### Knowledge Sharing Portal

| XXXXX | XXXXX |
Evidence –based content

Preventing and Managing Delirium

1. The evidence in the prevention of delirium favours multi-component interventions (see below). This is ideally suited to optimizing non-clinical hospital processes can play a key role in an organization-wide delirium.

Where applicable, the evidence from the literature is organized by SFH Framework domain tabs, reinforcing organization-wide approaches.

<table>
<thead>
<tr>
<th>Examples of Interventions within Evidence-Informed Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OS ORGANIZATIONAL SUPPORT STRATEGIES</strong></td>
</tr>
<tr>
<td>• Provide staff with education on delirium</td>
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<tr>
<td>• Allocate adequate staff</td>
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<tr>
<td>• Develop policies and guidelines over harmful procedures (e.g. indwelling catheters)</td>
</tr>
<tr>
<td><strong>PC PROCESSES OF CARE STRATEGIES</strong></td>
</tr>
<tr>
<td>• Routinely screen for delirium and changes in cognitive function</td>
</tr>
<tr>
<td>• Encourage or provide assistance with eating and drinking to ensure proper positioning, nutrition supplements as needed</td>
</tr>
<tr>
<td>• Provide regular bowel routines to avoid constipation</td>
</tr>
<tr>
<td>• Minimize use of indwelling catheters</td>
</tr>
<tr>
<td>• Provide oxygen therapy and chest physiotherapy as needed</td>
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</tbody>
</table>
Provincial SFH Action Priorities

- **Functional Decline**
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- **Transitions In Care**
  - Implement practices and developing partnerships that promote interorganizational collaboration with community and post-acute services
Mobilization of Vulnerable Elders

Co PI: B Liu, S Straus

Sunnybrook HSC
St. Michael’s Hospital
Baycrest
Mt. Sinai Hospital
Knowledge-to-Action Cycle

- **Identify, Review, Select Knowledge**
- **Identify Problem**
- **Knowledge Inquiry**
- **Synthesis**
- **Products/Tools**
- **Tailoring Knowledge**
- **Assess Barriers to Knowledge Use**
- **Adapt Knowledge to Local Context**
- **Select, Tailor, Implement Interventions**
- **Monitor Knowledge Use**
- **Evaluate Outcomes**
- **Sustain Knowledge Use**

Graham et al., 2006
Complications of Immobility

**Respiratory System**
- Decreased lung volume
- Pooling of mucus
- Cilia less effective
- Decreased oxygen saturation
- Aspiration
  - Atelectasis

**Gastrointestinal System**
- Reflux
- Loss of appetite
- Decreased peristalsis
- Constipation

**Circulatory System**
- Loss of plasma volume
- Loss of orthostatic compensation
- Increased heart rate
- Development of DVT

**Psychological**
- Anxiety
- Depression
- Sensory deprivation
- Learned helplessness
- Delirium

**Musculoskeletal System**
- Weakness
- Muscle atrophy
- Loss of muscle strength by 3-5%
- Calcium loss from bones
- Increased risk of falls due to weakness

**Genitourinary System**
- Incomplete bladder emptying
- Formation of calculi in kidneys and infection
"...rest in bed is anatomically, physiologically and psychologically unsound. Look at a patient lying long in bed. What a pathetic picture he makes! The blood clotting in his veins, the lime draining from his bones, the scybala stacking up in his colon, the flesh rotting from his seat, the urine leaking from his distended bladder and the spirit evaporating from his soul."
## Selected RCT evidence for early mobilization

<table>
<thead>
<tr>
<th>Surgical Dx</th>
<th>Many RCTs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pneumonia</strong></td>
<td>↓ LOS 5.8 vs. 6.9 days (Mundy Chest 2003;124:883-889)</td>
</tr>
<tr>
<td><strong>Stroke</strong></td>
<td>↑ Barthel Index at 3 months, Earlier return to walking 3.5 vs. 7 days P=0.03 (Cumming TB Stroke 2011; 42 :153)</td>
</tr>
<tr>
<td><strong>Cochrane Review (2009)</strong></td>
<td>↑ Discharge to home, NNT=16, ↓ LOS by 1.08 days (-1.93 to -0.22)</td>
</tr>
</tbody>
</table>
- 83% of measured hospital stay spent in bed
- Median time spent standing or walking = 43 minutes or 3% of day

Brown, C et al JAGS 2009;57:1660
Baseline Data

% in bed unit 1

% in bed Unit 2
Processes of Care

Institution-related

Organizational Support
Physical Environment

Attitudinal factors

Ethics in Clinical Care & Research
Emotional & Behavioural Environment

Patient-related

Processes of Care

Treatment-related

Active Health Services,
Physical Environment

Fishbone diagram

- **Family**
  - Don’t want patient to fall
  - “Better to rest”

- **Patient related**
  - Doesn’t want to
  - Too sick
  - Confused

- **Corporate**
  - Staffing ratio
  - Competing priorities

- **Treatment**
  - Lack of order
  - IV/Catheter

- **Staff**
  - Negative attitude
  - Not my job
  - No time
  - Lack of confidence

- **Physical environment**
  - Clutter in hallway
  - Lack of assistive devices
  - No where to walk
  - No where to sit

**Patients are left in bed**
Knowledge-to-Action Cycle

Select, Tailor, Implement Interventions

Monitor Knowledge Use

Evaluate Outcomes

Assess Barriers to Knowledge Use

Sustain Knowledge Use

Adapt Knowledge to Local Context

Identify, Review, Select Knowledge

Identify Problem

Knowledge Inquiry

Synthesis

Products/Tools

KNOWLEDGE CREATION

Graham et al., 2006
Goals of MOVE ON

- Mobility assessment within 24 hours of the decision to admit and reassessment daily
- At least three times a day, progressive, scaled mobilization
Mobility Assessment Algorithm

Environment Check:
- Chair/wheelchair is set-up beside the bed on patient’s stronger side (as applicable)
- Chair is against a firm surface
- Brakes are on the bed and the chair (if applicable)
- Lines and tubes are positioned properly

Patient position/set-up:
- Patient is seated at the edge of the bed with 1/3 of patient’s thigh on bed surface
- Bed height is high enough that patient’s hips are just above their knees with feet on the floor
- Patient’s feet are hip width apart and are behind their knees
- Patient is wearing appropriate footwear to prevent slipping
- Appropriate gait aid available (if necessary)
- Consider OT referral for cognitive, visual, perceptual and impaired ADL issues affecting mobility

Transfer to Chair:
- Have a firm hold on the patient – hands around patient’s buttock, hips, or holding their hand
- Avoid pulling up through patient’s shoulder
- Block patient’s weaker leg (if applicable) while transferring to chair to avoid knee giving out

Mobility Level A
- Can they walk a short distance?
  - Yes
    - Independent
    - Supervision or 1 assist
  - No
    - 2+ assist

Mobility Level B
- Can they transfer to a chair?
  - Yes
    - Independent
    - Supervision or 1 assist
  - No
    - 2+ assist

Mobility Level C
- Can they sit at edge of bed?
  - Yes
    - Independent
    - Supervision or 1 assist
  - No
    - 2+ assist

- Can they roll side to side?
  - Yes
    - Independent
    - Supervision or 1 assist
  - No

- Responds to verbal or gentle tactile stimuli?
  - Yes
    - Independent
    - Supervision or 1 assist
  - No

- Can they straighten 1 or both legs while sitting at edge of bed?
  - Yes
    - 2 legs
  - No
    - 1 leg

- Can they stand? (with or without gait aid)
  - Yes
    - Independent
    - Supervision or 1 assist
  - No

- Try 1 person to assist to stand
- Try 1-2 person to assist to stand
Simplified Mobility Assessment Algorithm

1. Can they respond to verbal stimuli?
2. Can they roll side to side?
3. Can they sit at edge of bed?
4. Can they straighten one or both legs?
5. Can they stand?
6. Can they transfer to a chair?
7. Can they walk a short distance?

Mobility Level

A
B
C

Develop an individualized mobility care plan

RGP  moveit  moveON
A Review of the ABC’s of Mobility

- **A**: Ambulates with or without assistance
- **B**: Bed to chair transfers
- **C**: Cannot stand to transfer
• Daily assessment of mobility status
• Mobilize three times daily
• Incorporates interprofessional teamwork and attitude awareness training
• Multipronged tailored education
First step is to dangle
To Chair
Respiratory ICU
Intermountain Medical Center
Salt Lake City, Utah
Senior Friendly Hospital Provincial Strategy

PHASE 1

Objective
• Identify current state

Plan
• Hospital self-Assessment
• LHIN-level roll-up
• Provincial roll-up

PHASE 2

Objective
• Close the gap

Plan
• Implement hospital improvement plans
• Develop key enablers

PHASE 3 - ONGOING

Objective
• Monitor and sustain hospital and system improvements

Future State
• Prevent functional decline
• Improve patient experience
• Enable hospital staff
• Improve equity
Indicator Working Group

- Dr. Barbara Liu (Co-Chair), RGP Toronto
- Rhonda Schwartz (Co-Chair), Baycrest Centre
- Ken Wong, RGP Toronto
- Michelle Rey, Health Quality Ontario
- Rebecca Comrie, Health Quality Ontario
- Annette Marcuzzi, Central LHIN
- Marilee Suter, Central East LHIN
- Brian Putman, North Simcoe Muskoka LHIN
- Minnie Ho, ICES
- Dr. Carrie McAiney, St. Josephs’ Healthcare Hamilton
- Dr. John Puxty, RGP SE Ontario
- Dana Chlemitsky, University Health Network
- Dr. Sharon Marr, RGP Central Ontario
- Kim Kohlberger, Halton Healthcare
- Catherine Cotton, St. Joseph's Health Centre
- Kelly Milne, RGP Eastern Ontario
Indicators workplan/timeline

<table>
<thead>
<tr>
<th>Phase</th>
<th>March 2012</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
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<tbody>
<tr>
<td>I</td>
<td>Envirnml scan Lit review Shortlist 1</td>
<td>Delphi voting Shortlist 2 Meeting for consensus</td>
<td>Delphi voting Shortlist 3 Meeting for consensus</td>
<td>Report drafting Submission LHINs</td>
<td>LHIN Review</td>
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<tr>
<td>II</td>
<td>Pilot testing</td>
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<td>III</td>
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Sep 2012 | Oct | Nov | Dec | Jan | Feb | Mar 2013
LHINs Select Indicators
Patient & Care Team

Alignment and momentum

Sustain
The goals of the SFH (win-win-win)

- **Patient / family**
  - Minimize risk, improve safety
  - Maximize functional ability, improve outcomes
  - Improve care experience & satisfaction

- **Staff**
  - Enabled to deliver best practice
  - Improve satisfaction

- **Hospital Strategic Alignment**
  - Improve quality
  - Reduce adverse events & iatrogenic complications
  - Improve capacity for independent living
  - Reduce ALC and readmissions
Populations standards working group

- Draft standards for system planning being piloted
- Receptive to expanding ROPs to include more senior relevant standards.
Next steps

- Knowledge exchange and networks
  - LHIN-wide networks and provincial collaborative
- SFH is a continuous cycle
  - Expanded improvement plans
  - Enhanced toolkit resources
- LHIN Integrated health services plans
- MOHLTC Seniors Strategy
- HQO QIPs
“….a focus on geriatrics as the solution, not the problem.”

J. Bennett, 2010
TC LHIN
- C Orridge
- V Sakelaris
- R Cook
- T Martins
- G Whitehead
- S Smit

TC LHIN SFH Taskforce
- J Bennett (Co-Chair)
- B Liu (Co-Chair)
- M Codjoe
- C Cotton
- S VanDeVelde-Coke
- P Cripps-McMartin
- L Dess
- C Levy

TC LHIN SFH indicator Working Group
- J Bennett (Co-Chair)
- B Liu (Co-Chair)
- C Cotton
- L Dess
- C Levy

C Millar
- J O’Neill
- M McCarthy
- S VanDeVelde-Coke
- K Velji
- J Walsh

SFH LHIN Leads Working Group of ON
- A Anderson
- H Willis
- P Istvan
- J Girard
- T Martins
- S Colwell
- G Whitson Shea
- A Marcuzzi
- M Auchinleck
- S Isaak
- B Laundry
- B Villella
- S Stewart
- C Russell
- K Tasala
- N Jaffer
- C LeClerc

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www.rgp.toronto.on.ca
www.seniorfriendlyhospitals.ca