Senior Friendly Hospitals: A Provincial Strategy & Let's MOVE ON

Geriatrics Refresher Day
Ottawa
March 21, 2012

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Executive Director

Senior Friendly Hospitals

REGIONAL GERIATRIC PROGRAM OF TORONTO

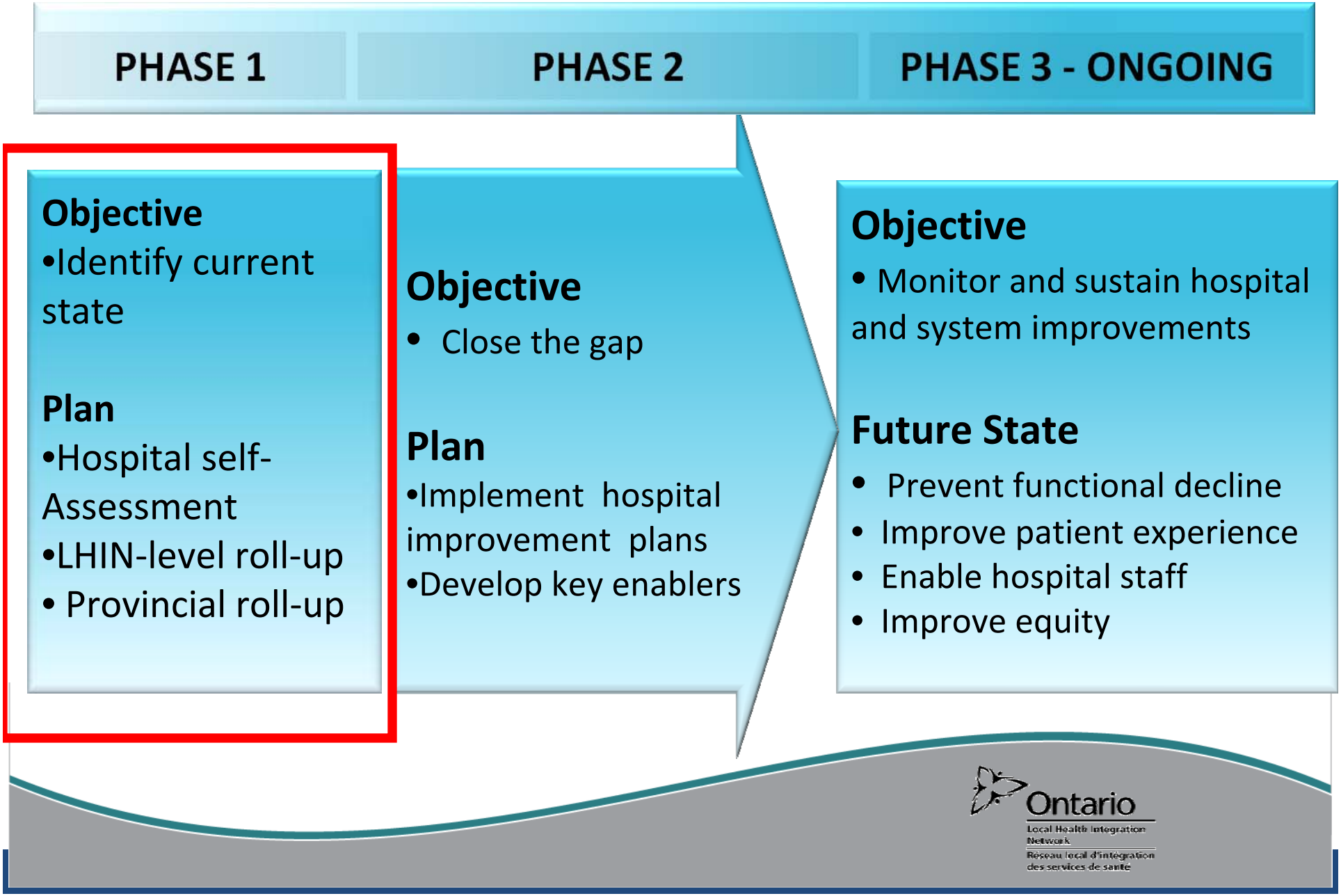
Outline

- 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



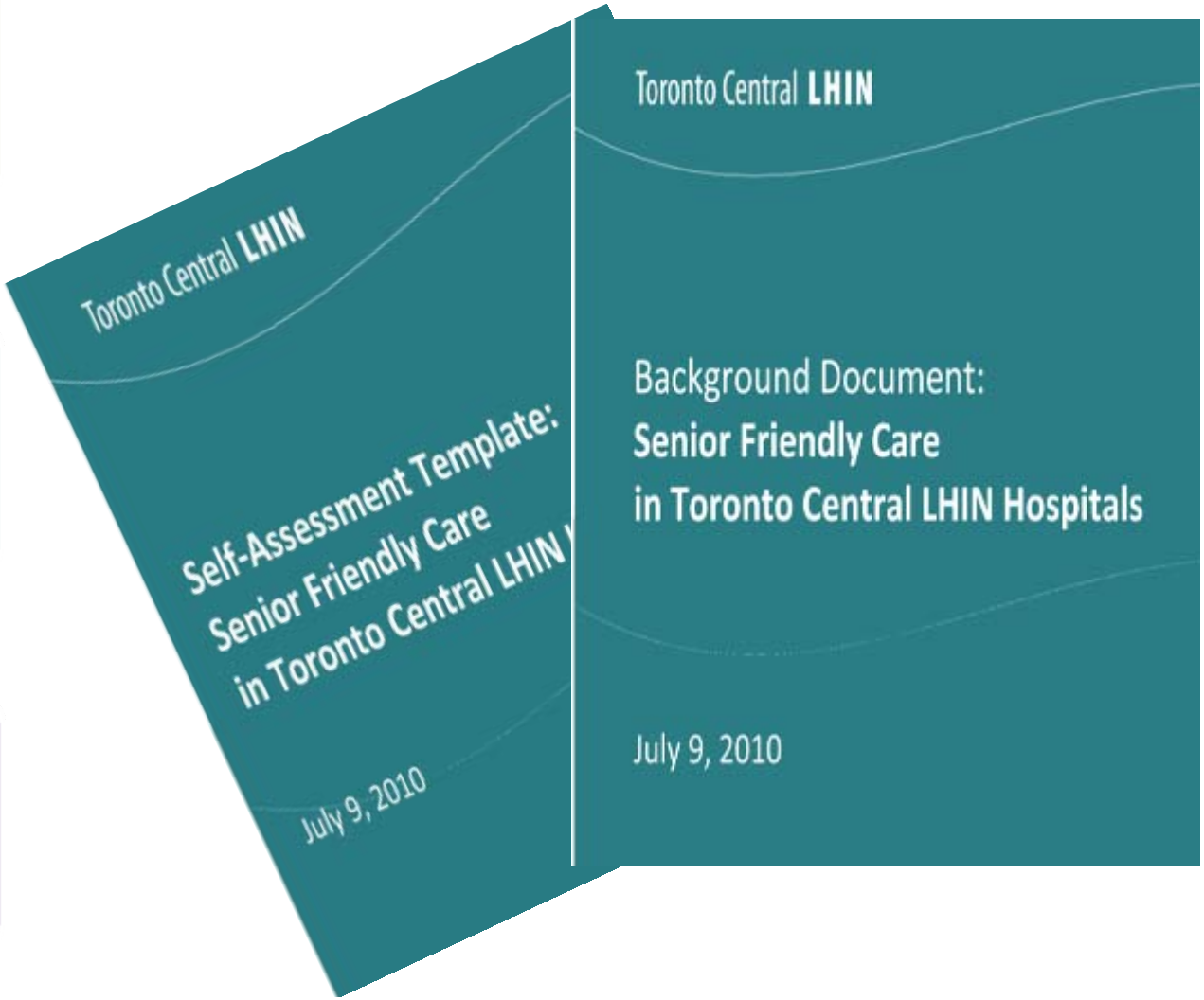
Senior Friendly Hospital Care in the TC LHIN

TCLHIN Integrated Health Services Plan 2010-2013

SFH Background document and Hospital Self Assessment

TCLHIN Summary report

Dec 2010



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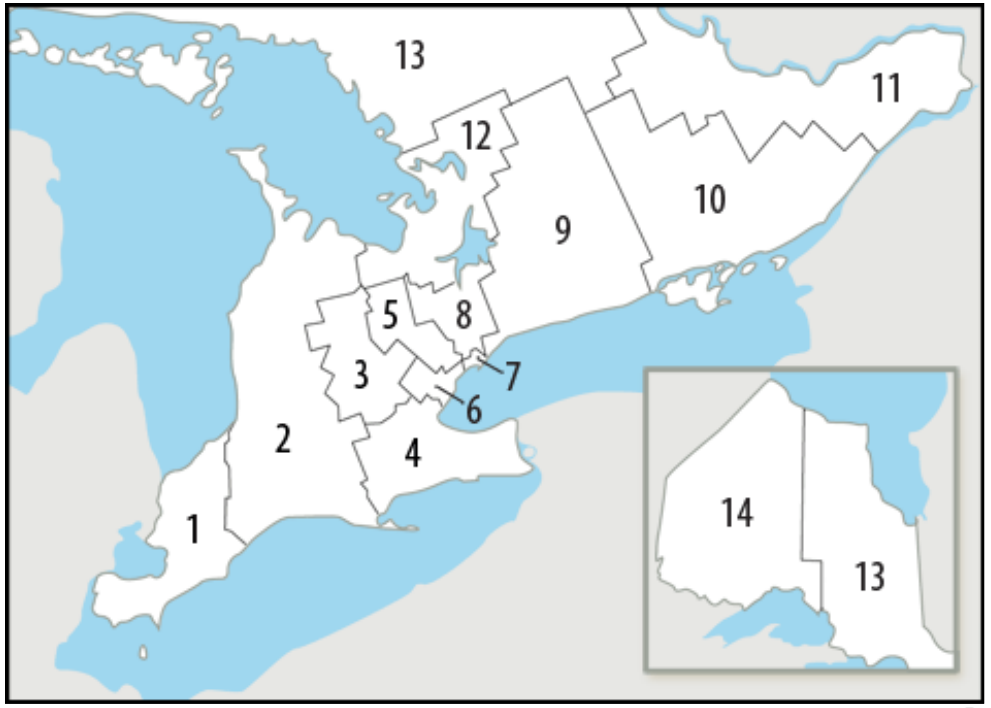
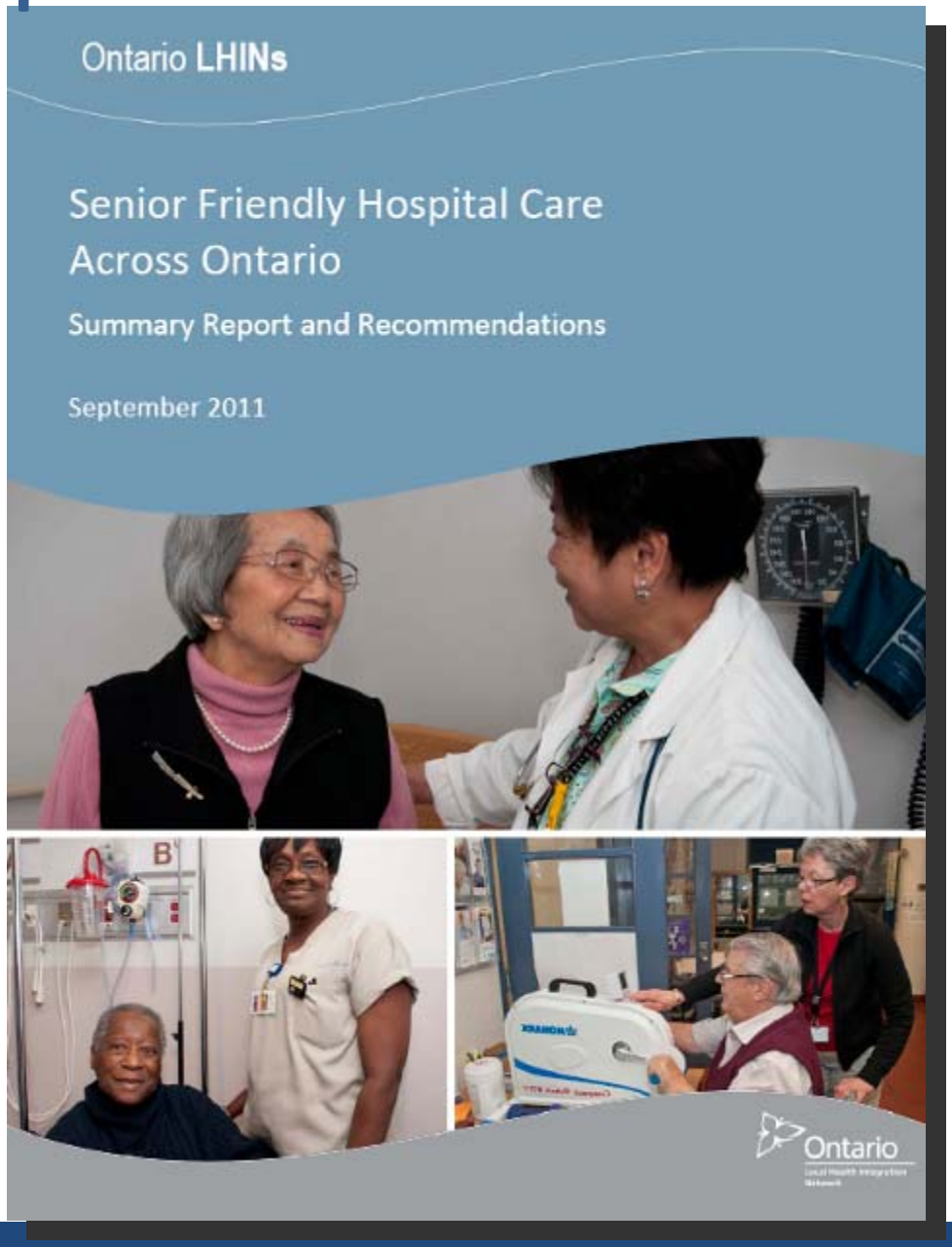
Senior Friendly Hospital Care in Ontario

- 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



Provincial Summary Report

- 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

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Emotional and Behavioural Environment

Patient-Centred Care Designed with Seniors in Mind

- 28% of hospitals - age-specific measures in satisfaction or quality improvement initiatives

☆**S**taff for way-finding, personal menu assistance

Supporting Communication and Patient Involvement in Care

☆ hearing amplifiers, translation services

☆ team rounds at the bedside

☆ Early goal setting discussions

☆ discharge planning information packages

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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

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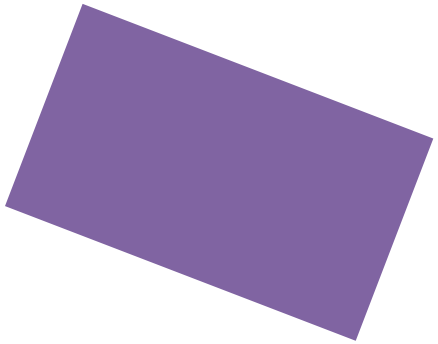
Physical Environment



- 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

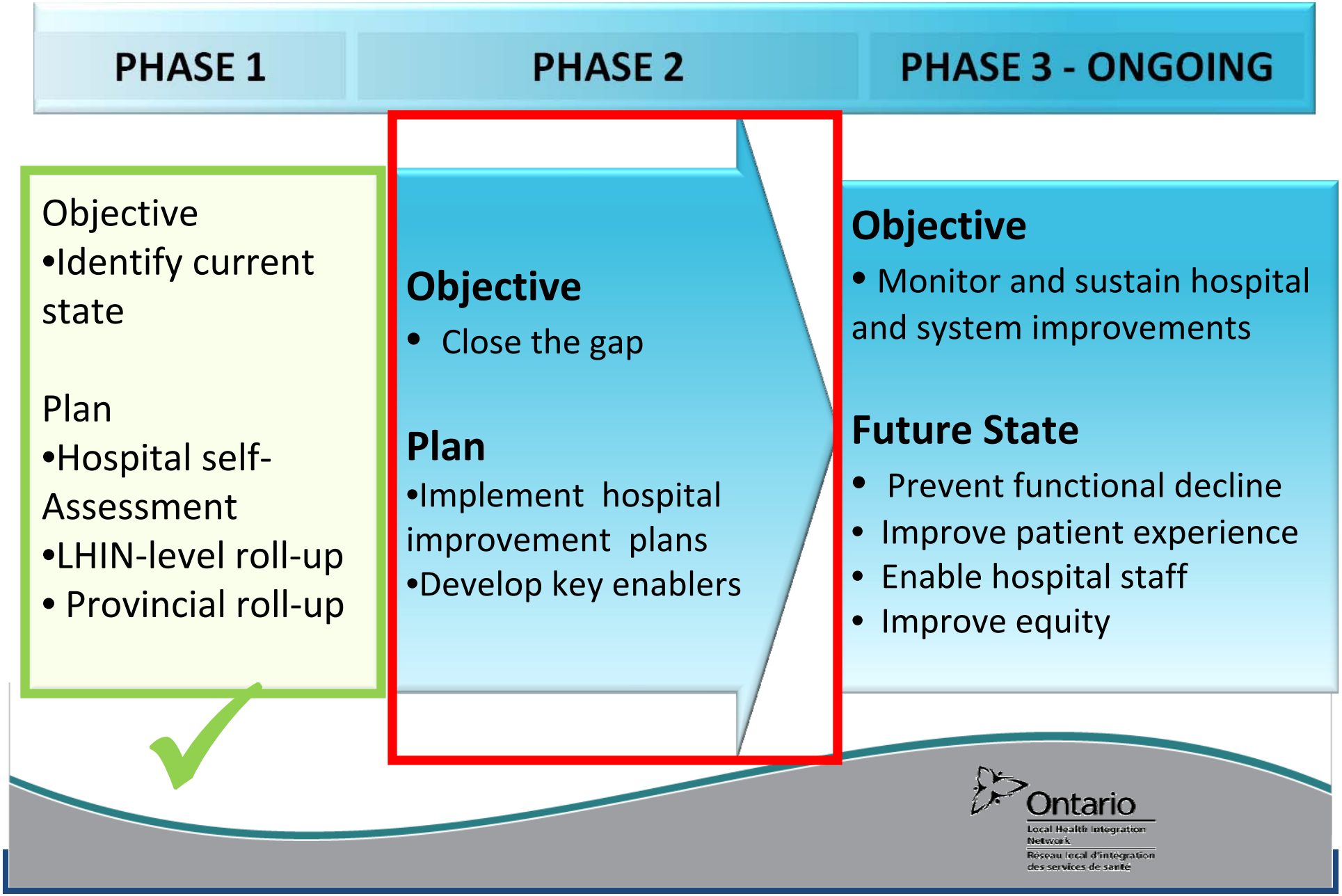
- **Delirium**
  - Implement interprofessional delirium screening, prevention, and management protocols across hospital departments to optimize cognitive function

- **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

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	
(3) Geriatrics Champions	• Serve as peer-to-peer resource and coach in support of mobility protocols • Reinforce formal knowledge-to-practice activities
(4) HR Development	• Formal education on mobility protocols
Emotional & Behavioural Environment	
7) 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
(8) Senior Friendly Person-Centred and Diversity Practices	
Ethics in Clinical Care and Research	
(9) Ethicist Services Available	• Ensure the availability of ethicist or ethics committee to assist clinical teams, patients, and families in complex decision making
(10) Policies for Autonomy and Consent/Capacity	
Physical Environment	
(11) 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



Toolkit Working Group

- Dr. Barbara Liu (Co‐Chair), RGP Toronto
- Dr. Gary Naglie (Co‐Chair), Baycrest Centre
- Ken Wong, RGP Toronto
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- David Jewell, RGP Central ON
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- 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

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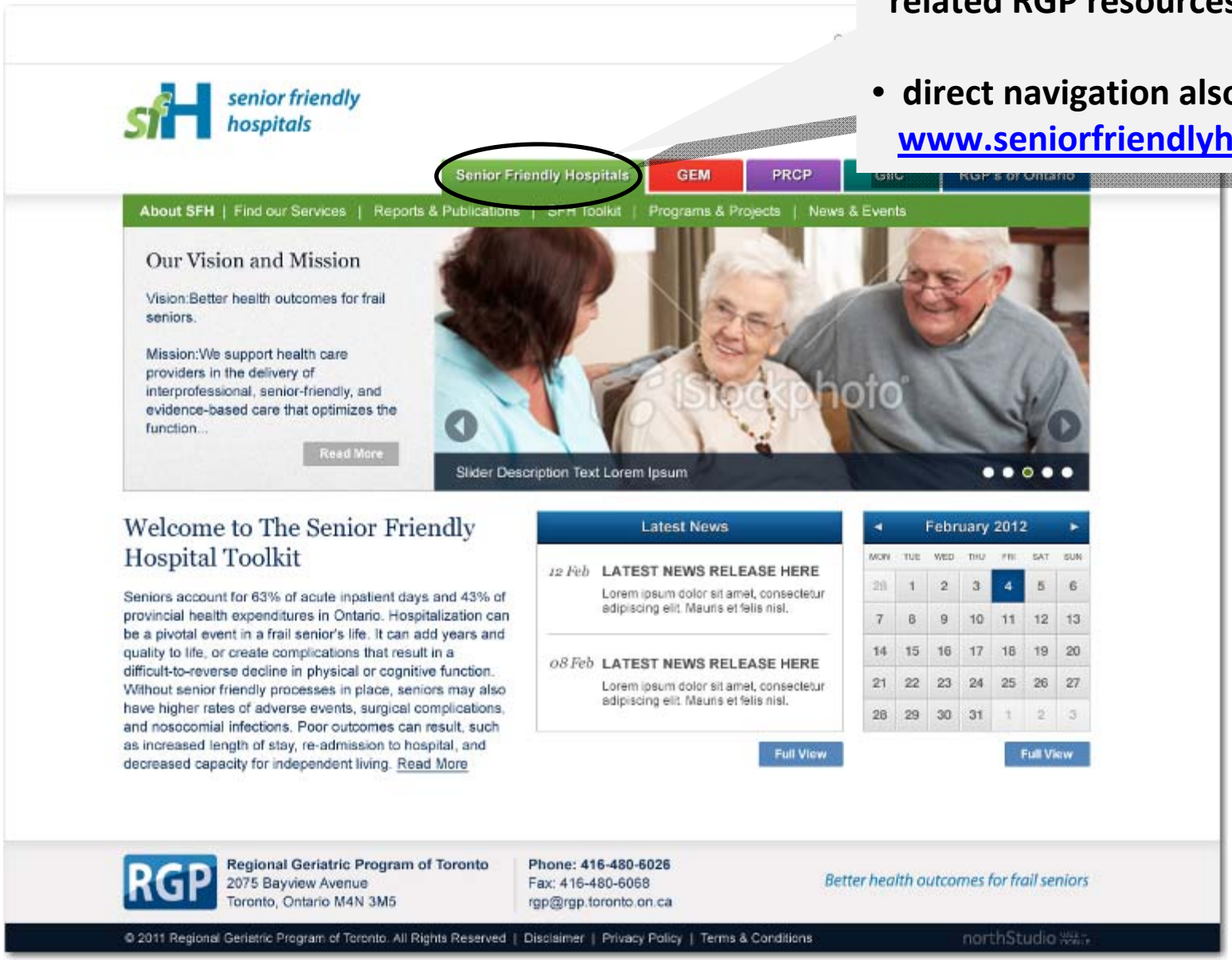
SFH Toolkit Home Page

- **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**



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

Confusion Assessment Method (CAM)
Delirium Observation Screening Scale (DOSS)
CAM-ICU
Intensive Care Delirium Screening Checklist (ICDSC)

Knowledge Sharing Portal

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DELIRIUM SCREENING AND DETECTION

The Confusion Assessment Method (CAM)

OVERVIEW:

The Confusion Assessment Method (CAM) was originally developed in 1988-19 of delirium. The CAM is consistent with the DSM-IV criteria for delirium. It was applications to provide a standardized method for non-psychiatrically trained h and accurately.

AUTHORS/PRIMARY REFERENCE:

Inouye SK, CH vanDyck, CA Alessi, S Balkin, AP Siegal, and RI Horwitz (1990). Cl Method. A new method for detection of delirium. *Annals of Internal Medicine*

STRUCTURE OF THE TOOL:

The most basic form of the CAM comprises four items, each reflecting a cardin

1) Acute onset
2) Inattention
3) Disorganized thinking
4) Altered level of consciousness

A positive finding for delirium requires the presence of items 1 and 2, and eith

PSYCHOMETRIC PROPERTIES:

- Sensitivity – 74-93% (95% confidence interval)[4]
- Specificity – 87-96% (95% confidence interval)[4]
- Inter-Rater Reliability – κ=1.00 (for presence/absence of delirium), κ=0.93 (

TARGET POPULATION AND SETTING:

- Confused older people in hospital
- Inpatient Acute Units
- Emergency Departments

INTENDED USER(S):

- Medical, nursing staff, and other clinicians – training is recommended for o
- An instruction manual is available on-line (see below in "Where to get the C

NOTES ON USING THE CAM:

- Administration of the CAM takes 5-10 minutes
- It is recommended that the CAM be combined with formal cognitive assess test
- The CAM has been translated into Chinese, Dutch, Finnish, French, German,

Evidence –based content

SCROLL

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

Preventing and Managing Delirium

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

Examples of Interventions within Evidence-Informed Preven

OS ORGANIZATIONAL SUPPORT STRATEGIES

- Provide staff with education on delirium
- Allocate adequate staff
- Develop policies and guidelines over harmful procedures (e.g. indwelling catheters)

PC PROCESSES OF CARE STRATEGIES

- Routinely screen for delirium and changes in cognitive functic
- Encourage or provide assistance with eating and drinking to e proper positioning, nutrition supplements as needed
- Provide regular bowel routines to avoid constipation
- Minimize use of indwelling catheters
- Provide oxygen therapy and chest physiotherapy as needed

SCROLL

Provincial SFH Action Priorities

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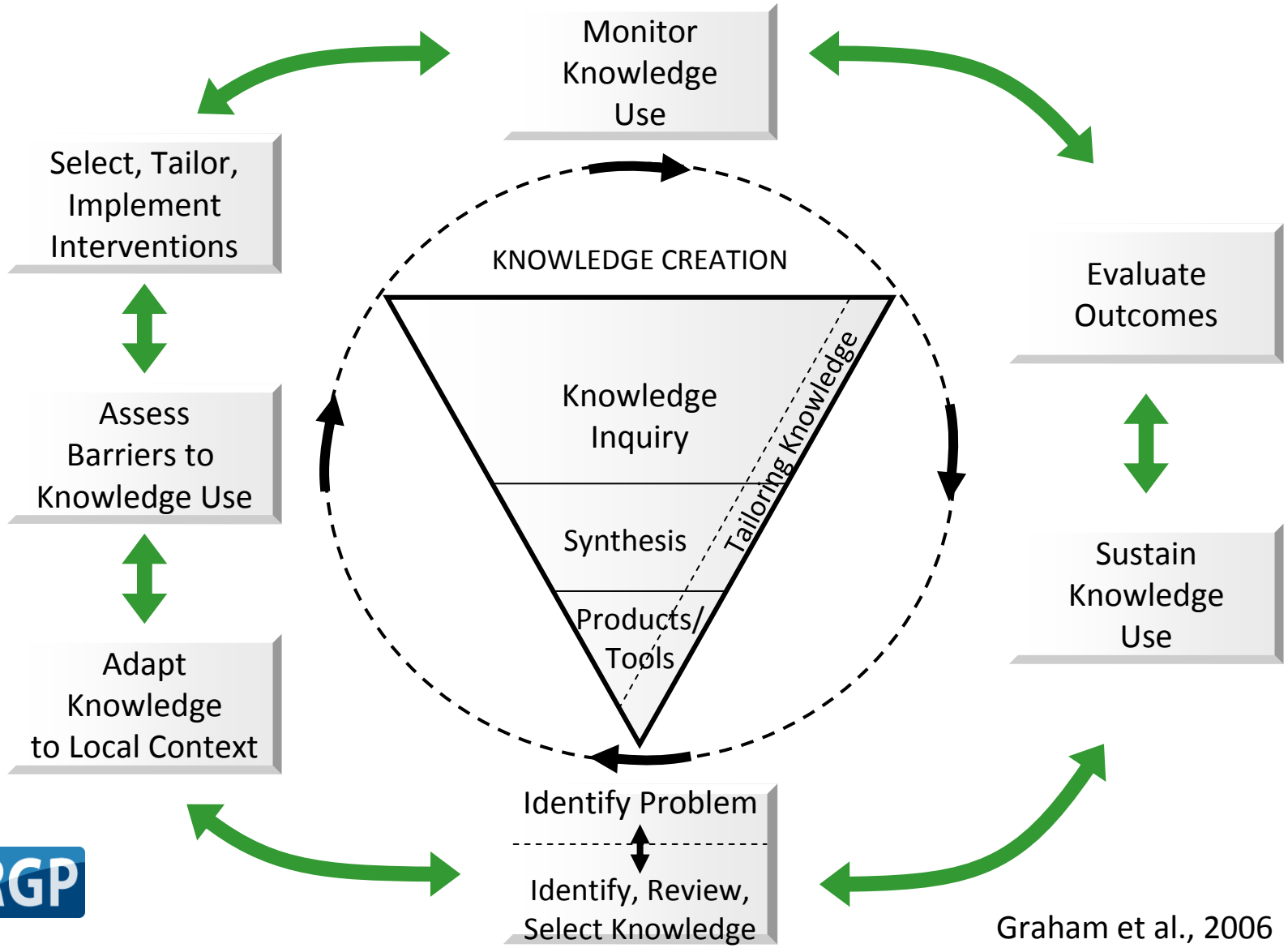
- Transitions In Care
  - Implement practices and developing partnerships that promote interorganizational collaboration with community and post-acute services

Mobilization of Vulnerable Elders

Co PI: B Liu, S Straus

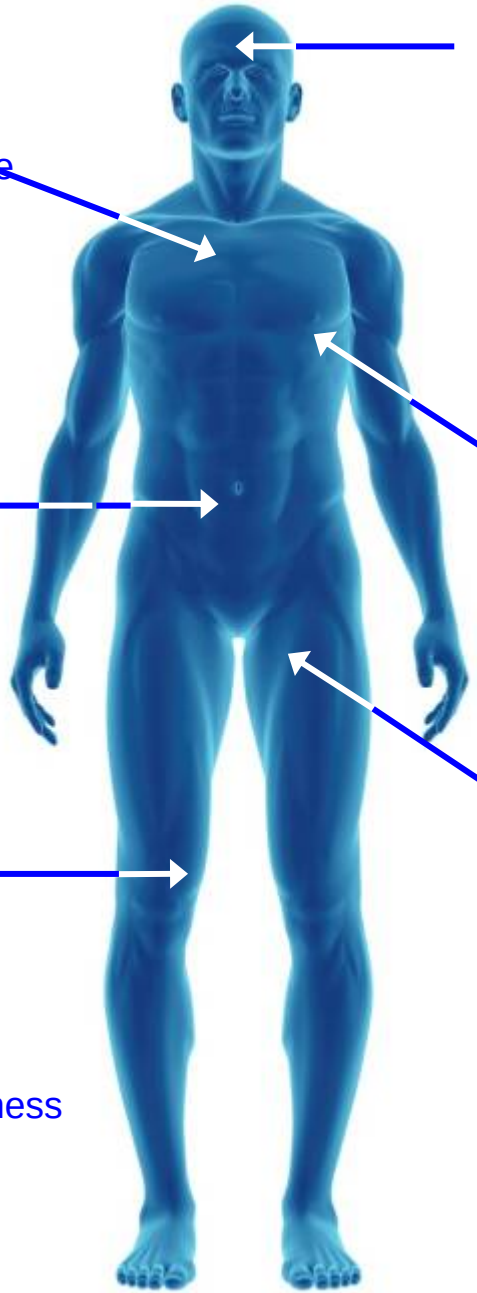
Sunnybrook HSC
St. Michael's Hospital
Baycrest
Mt. Sinai Hospital

Knowledge-to-Action Cycle



Graham et al., 2006

Complications of Immobility



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

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

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

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

Genitourinary System
- Incomplete bladder emptying
- Formation of calculi in kidneys and infection

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

DEC. 13, 1947 BRITISH MEDICAL JOURNAL 967

THE DANGERS OF GOING TO BED

BY

R. A. J. ASHER, M.D., M.R.C.P.

"...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."

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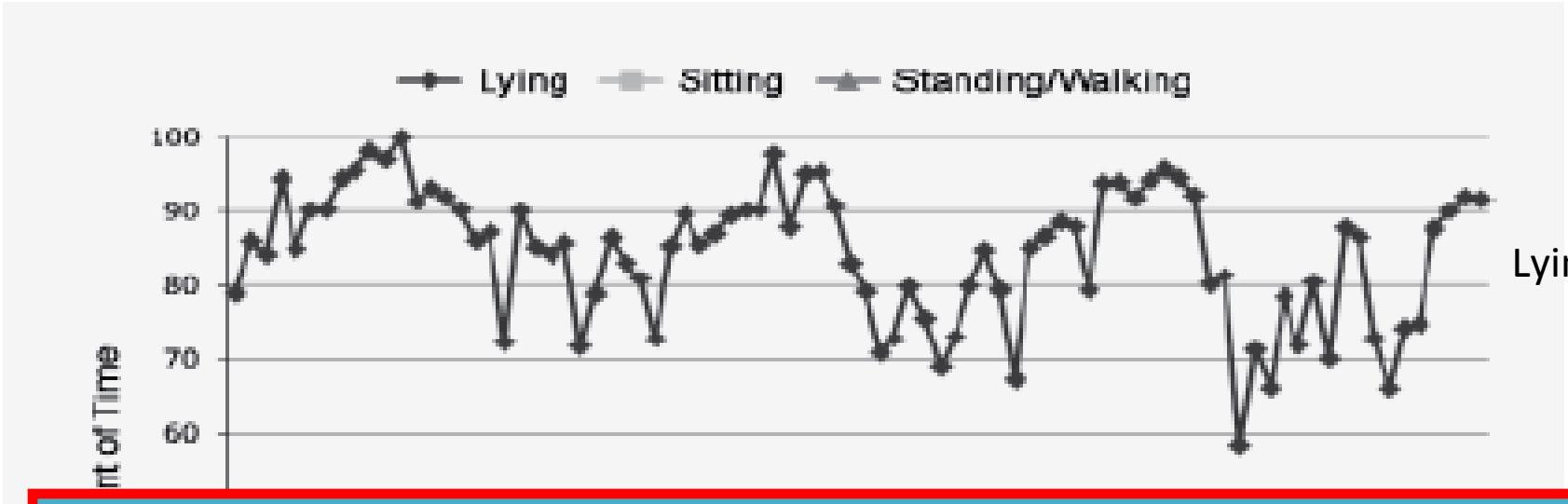
Selected RCT evidence for early mobilization

Surgical Dx	Many RCTs
Pneumonia	↓ LOS 5.8 vs. 6.9 days (Mundy Chest 2003;124:883-889)
Stroke	↑ Barthel Index at 3 months Earlier return to walking 3.5 vs. 7 days P=0.03 (Cumming TB Stroke 2011; 42 :153)
Cochrane Review (2009)	↑ Discharge to home, NNT=16 ↓ LOS by 1.08 days (-1.93 to -0.22)

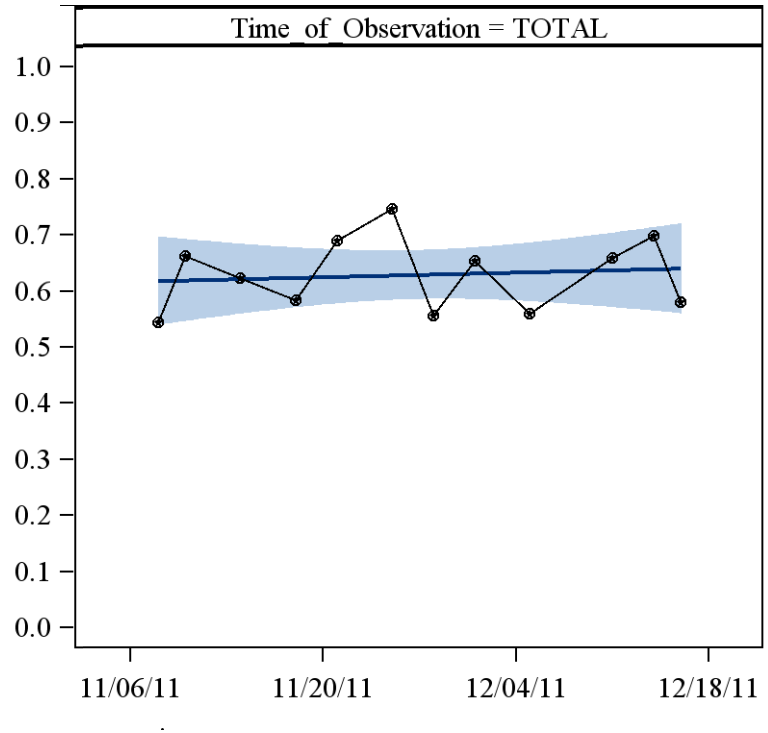


- 83% of measured hospital stay spent in bed
- Median time spent standing or walking
  = 43 minutes or 3% of day

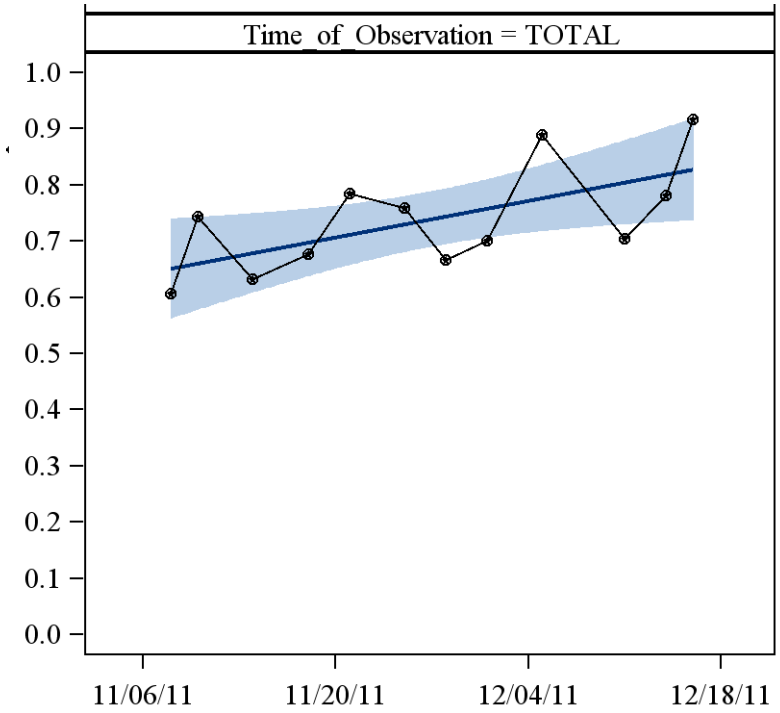
Brown, C et al JAGS 2009;57:1660

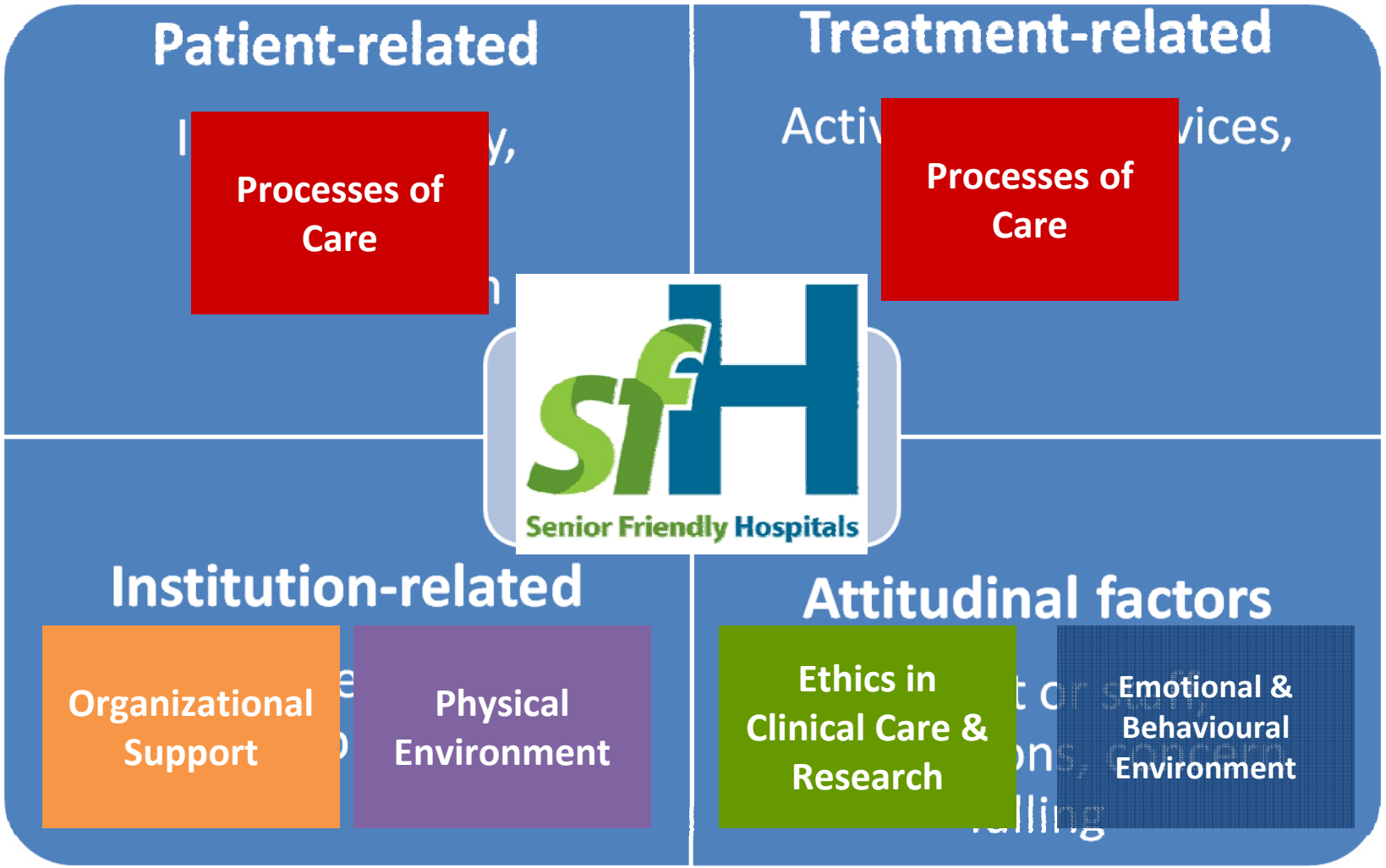
Baseline Data

% in bed unit 1



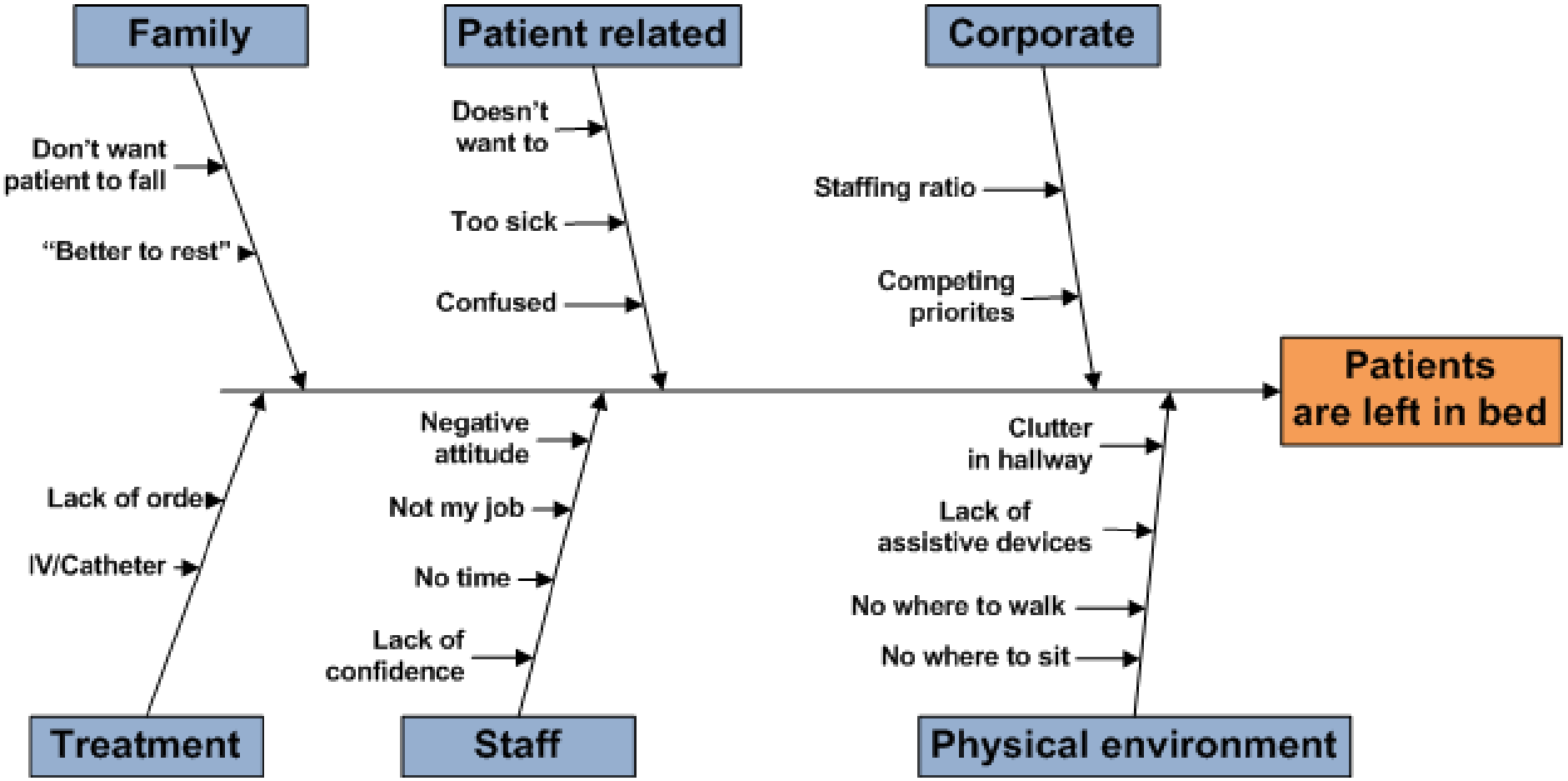
% in bed Unit 2



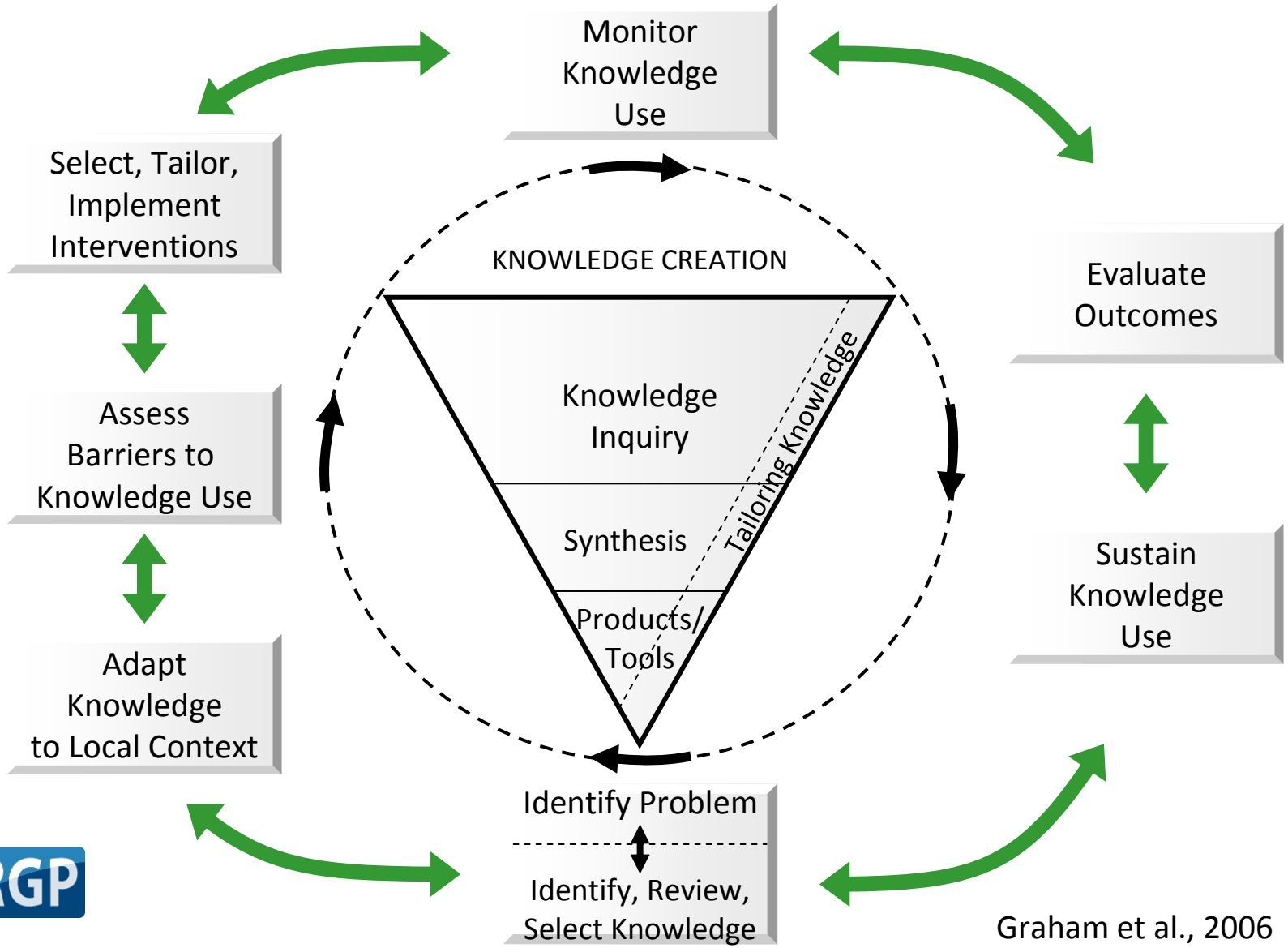


Brown, C et al J Hosp Med 2007;2:305

Fishbone diagram



Knowledge-to-Action Cycle



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:

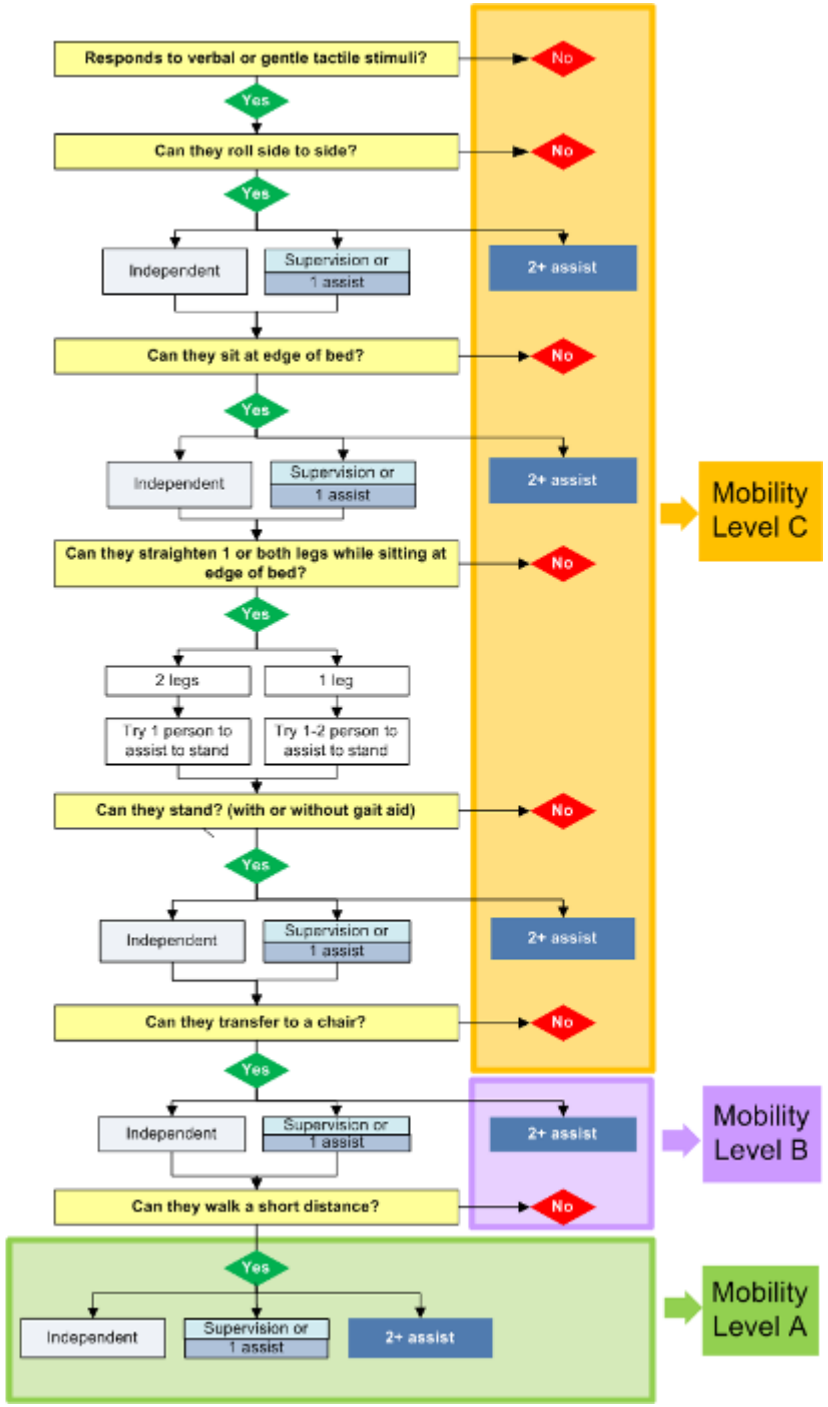
- Chair/wheelchair is set-up beside the bed on patient's stronger side (as applicable)
- Chair is against a firm surface
- Brakes are on the bed and the chair (if applicable)
- Lines and tubes are positioned properly

Patient position/set-up:

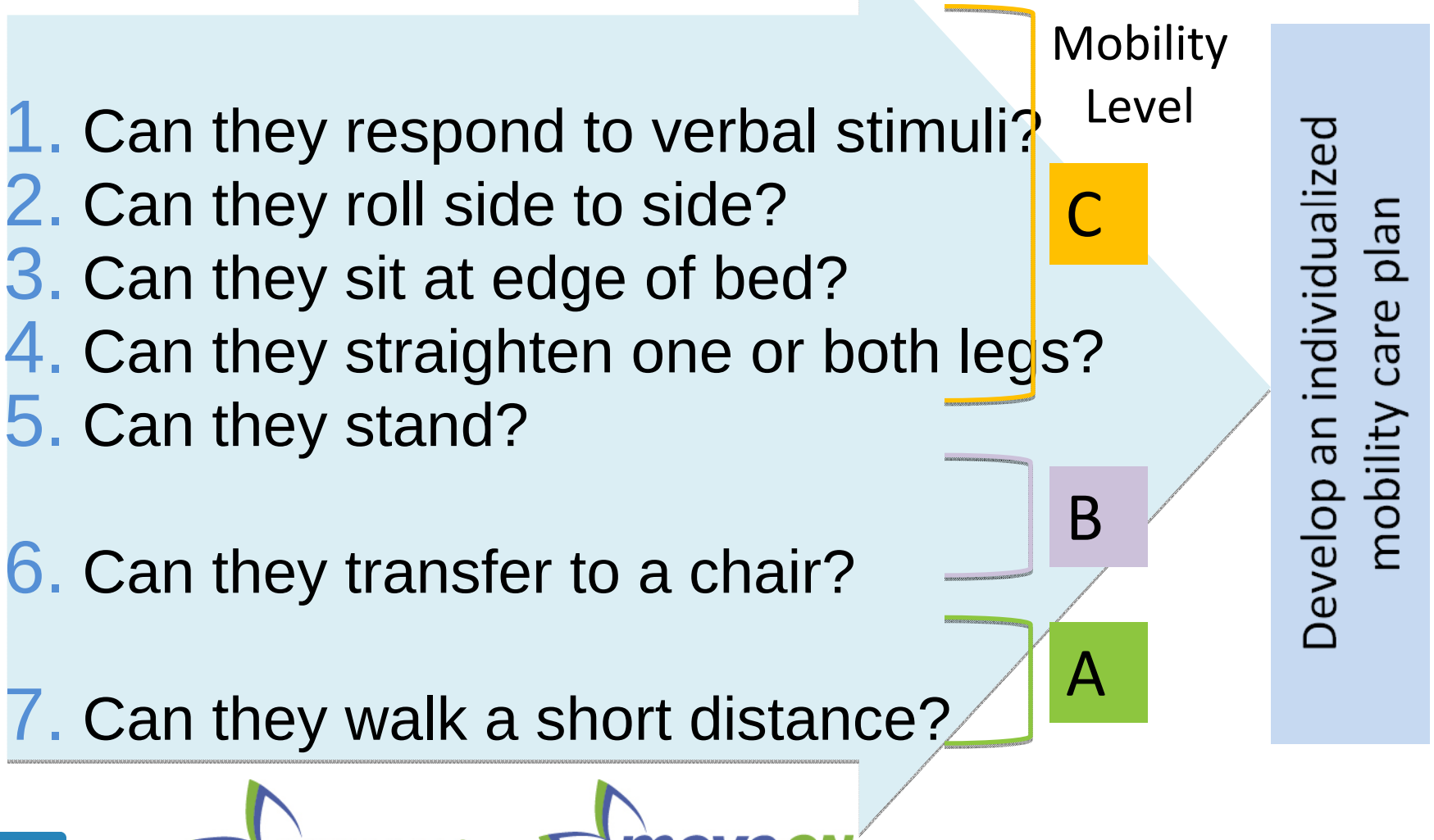
- Patient is seated at the edge of the bed with 1/3 of patient's thigh on bed surface
- Bed height is high enough that patient's hips are just above their knees with feet on the floor
- Patient's feet are hip width apart and are behind their knees
- Patient is wearing appropriate footwear to prevent 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



Simplified Mobility Assessment Algorithm



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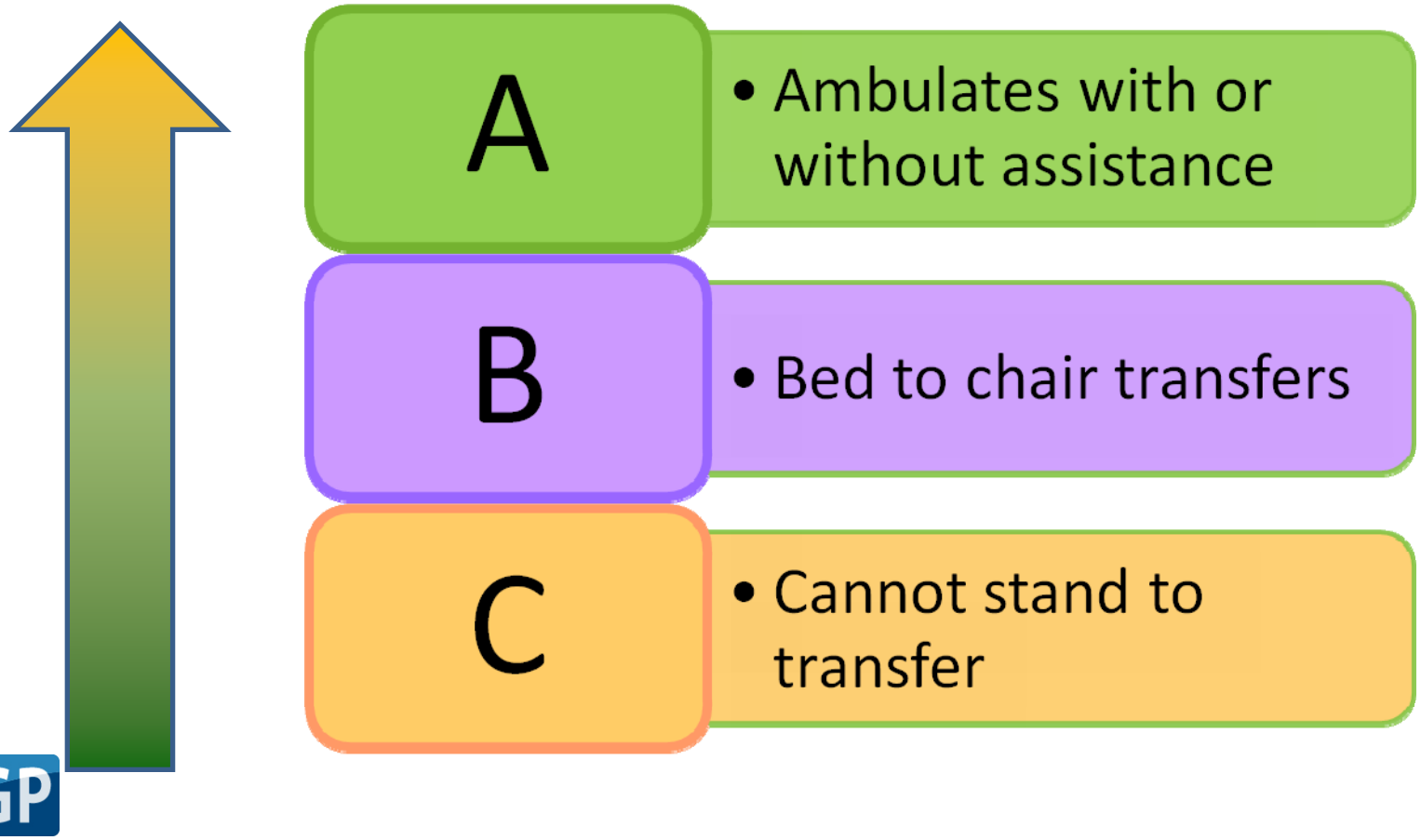
moveIT moveON

A Review of the ABC's of Mobility

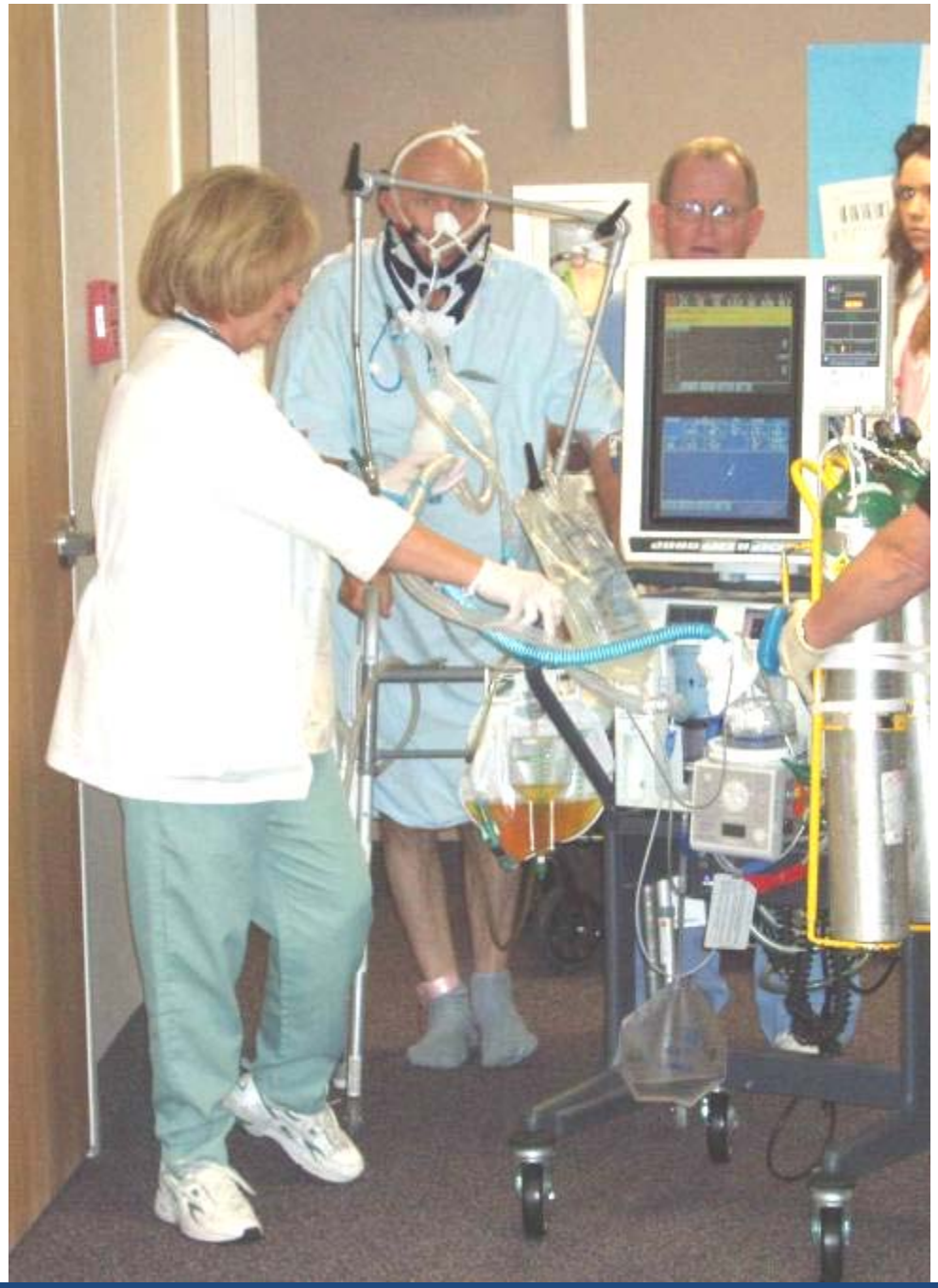


- Daily assessment of mobility status
- Mobilize three times daily
- Incorporates interprofessional teamwork and attitude awareness training
- Multipronged tailored education

moveIT moveON

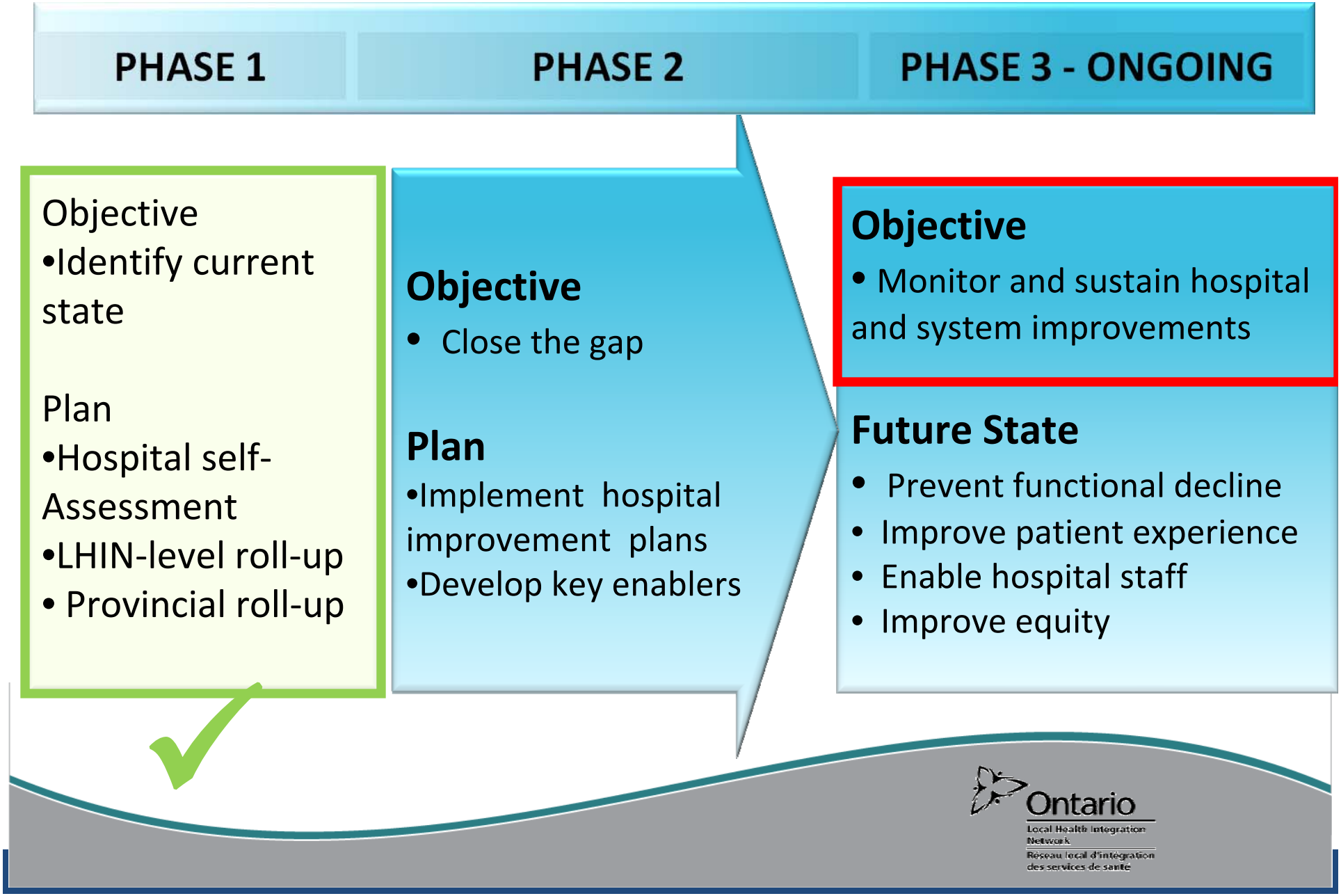
First step is to dangle

To Chair



Respiratory ICU
Intermountain Medical Center
Salt Lake City, Utah

Senior Friendly Hospital Provincial Strategy



Indicator Working Group

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- Rhonda Schwartz (Co‐Chair), Baycrest Centre
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- Michelle Rey, Health Quality Ontario
- Rebecca Comrie, Health Quality Ontario
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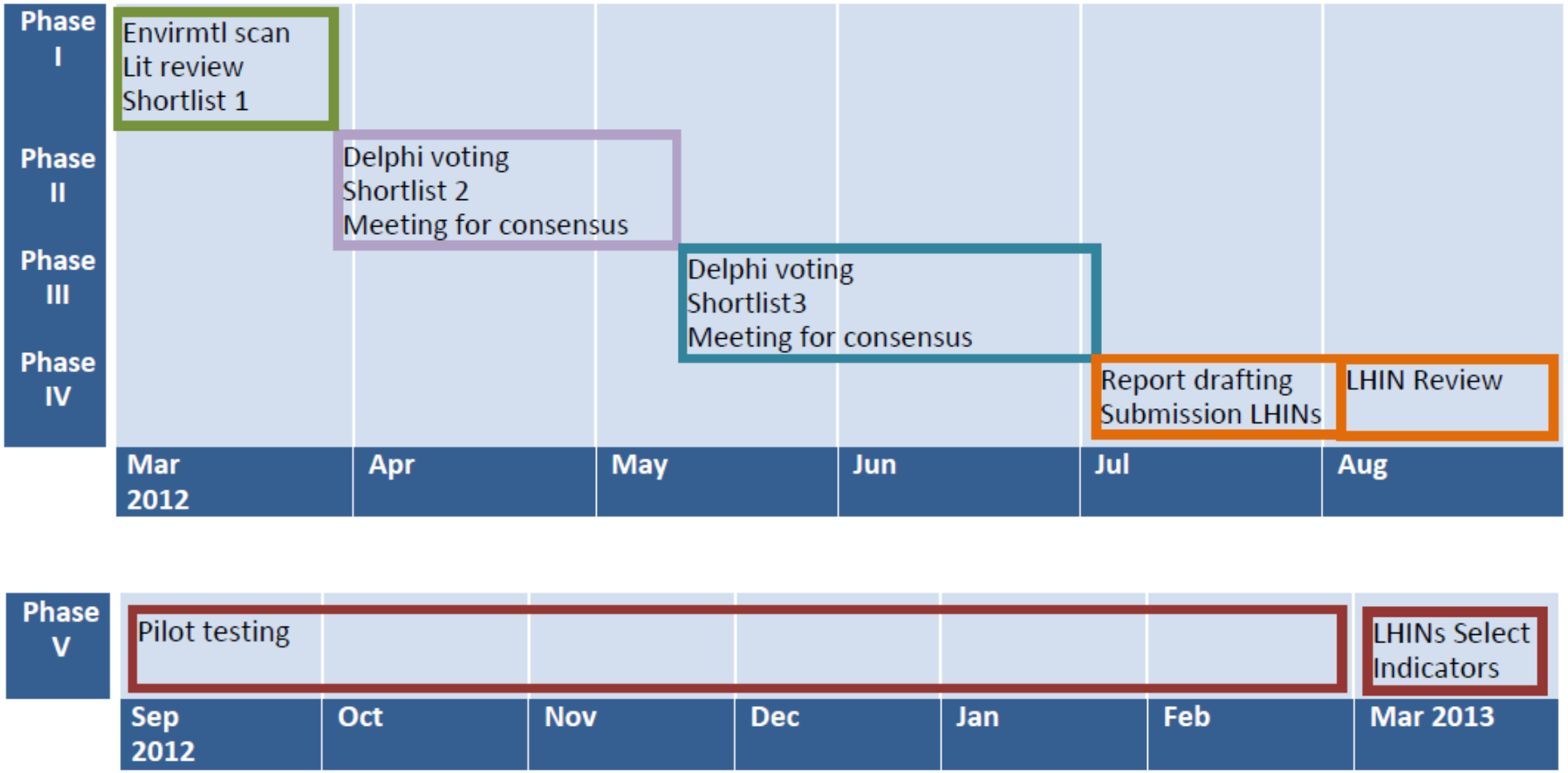
- Dr. John Puxty, RGP SE Ontario
- Dana Chlemitsky, University Health Network
- Dr. Sharon Marr, RGP Central Ontario
- Kim Kohlberger, Halton Healthcare
- Catherine Cotton, St. Joseph's Health Centre
- Kelly Milne, RGP Eastern Ontario

Indicators workplan/timeline



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

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National Round Table Meeting on Quality and Safety Standards for Older People in Canadian Hospitals

PI: B Liu, B. Parke, A Juby

Quebec City, April 19, 2012

CIHR IRSC

Populations standards working group

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

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

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


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RGPs
OF ONTARIO
Processes of Care
Organizational Support
Ethics in Clinical Care & Research
Physical Environment
Senior Friendly Hospitals

“….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
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- C Levy

TC LHIN SFH indicator Working Group

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- K Velji
- J Walsh

RGPs of ON

- K Wong
- D Jewell
- K Milne
- E Plain
- E McCarthy
- K Rossi
- M Awad
- D Ryan

SFH LHIN Leads Working Group of ON

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J Girard
G Whitson Shea
S Isaak
S Stewart
N Jaffer
H Willis
T Martins
A Marcuzzi
B Laundry
C Russell
C LeClerc
P Istvan
S Colwell
M Auchinleck
B Villella
K Tasala

SFH Toolkit Working Group of Ontario

G Naglie, B Liu – co-chairs, et al.

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Ontario
Toronto Central Local Health Integration Network

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