A Summary of Senior Friendly Care in Waterloo Wellington Local Health Integration Network Hospitals

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1. Executive Summary

The mix of urban and rural areas in the Waterloo Wellington LHIN creates significant and unique challenges in providing quality and patient-centred care to an aging population. As seniors are the primary users of hospital services, systematic changes will be necessary in both hospitals and the broader health system to ensure capacity and sustainability to respond to this elder care need. Moreover, given that seniors receive care throughout the hospital system, 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.

Reducing emergency department (ED) wait times and Alternative Level of Care (ALC) days are top priorities for the LHINS and the Ontario government. Enhancing the care of seniors in hospitals to increase their ability to transition safely from hospital to the community is an essential component of an integrated, system-wide effort to reduce the time people spend waiting in emergency departments and ALC beds. Additionally, a systematic approach to improving hospital processes and the environment for seniors will contribute to a hospital's capacity to meet the quality and safety improvements required under the Excellent for All Care Act.

A senior friendly hospital approach to care is one in which hospitals will compliment and build on existing hospital efforts and community based strategies already underway to enable a system of care that helps seniors maintain their independent functioning and remain in their homes for as long as possible.

To enable hospitals to take a systematic, evidence-based approach, the LHINs across the province have endorsed a five domain framework for Senior Friendly Hospitals developed by the Regional Geriatric Programs of Ontario designed to improve outcomes, reduce inappropriate resource use and improve client and family satisfaction:

1) **Organizational Support** reflects how the organization shows support for being a Senior Friendly Hospital though its organizational structures and processes.
2) **Processes of Care** reflects how the care and treatment of seniors takes into Account research and evidence regarding the physiology and pathology of aging, as well as social science research.
3) **Emotional and Behavioural Environment** reflects an organizational culture where staff interacts with older patients in a respectful, supportive, and caring way.
4) **Ethics in Clinical Care and Research** reflects how care providers, researchers, and others ensure that ethical issues are fully addressed with elderly patients in the context of their care and in research studies.
5) **Physical Environment** reflects whether the organization's physical space is sensitive to the capacities of elderly patients and their visitors.

The Waterloo Wellington LHIN, in partnership with its hospitals will be stewards and leaders in the systematic alignment of needs and resources by supporting partner hospitals in adopting the Senior Friendly Hospital Framework and integrating measurable objectives into the hospital service accountability agreements.

The first step in the Senior Friendly Hospital Strategy in the Waterloo Wellington LHIN included the completion of a self-assessment by hospitals to identify promising practices, gaps and opportunities for improvement. This summary report of the WW LHIN hospital self assessments represents a snapshot of the current state of senior friendly care in hospitals across the LHIN. The report also identifies strengths, promising practices, key enablers, areas for improvement and potential next steps in moving the Senior Friendly Hospital Strategy forward in Waterloo Wellington and across the broader system.

Seniors utilize a significant portion of hospital services in the Waterloo Wellington LHIN. In fact seniors account for 53% of acute hospital days and 71% of acute ALC days in the Waterloo Wellington LHIN. There is a substantial body of evidence that shows the hospital stay itself makes seniors more vulnerable to adverse events while in hospital and loss of functional ability, thereby contributing to longer hospitalizations and ALC.

The Senior Friendly Hospital Framework provides a common pathway to leverage positive change in any hospital. While all five components of the Senior Friendly Hospital Framework

are required for optimal outcomes, it is recognized that given the variation in resources and unique challenges across the WWLHIN, a phase-in approach to change may be more feasible and practical in its implementation. The Framework therefore supports the establishment of short, medium and long term change objectives and timelines.

Results from the hospital self assessment indicate that there exists a broad commitment to senior friendly care among hospitals in the WWLHIN. While generally recognizing that care to seniors is an evolving core business of their organizations, it was hospitals where there were specific goals for excellence in elder care identified in their strategic plans that had more explicit senior friendly practices in place versus an implicit focus on the older adult population.

 All hospitals expressed an interest in recruiting and developing staff with skill and training in the areas of best practice and geriatric competencies. However, they also expressed some common challenges such as shortages of staff with specialized training, the need to share full-time equivalents (FTEs) across several clinical areas versus dedicated to one specific clinical program and succession planning issues. Rural differences were also noted with both human resources and financial issues cited for recruitment and staff development. Despite shortages the WWLHIN has provided funding to hospitals for Geriatric Emergency Management (GEM) nurses leveraging this human resource for championing best practice education.

The self assessment also examined the clinical processes of care that are particularly relevant to seniors. Falls, restraint use, adverse drug reactions, pain management and pressure ulcers were clinical areas most frequently given attention of a clinical protocol and procedure for active monitoring although these might not all be senior-specific. Encouraging is the trend in protocol development for delirium and hydration/nutritional status. Less frequently reported to have protocols and/or mechanisms for active monitoring were continence and sleep management.

The emphasis on partnerships both internally and externally in identifying and coordinating care needs was a recurrent theme in the self assessments. The inclusion of interdisciplinary and

inter/intra organizational approaches were reported to build capacity and enhance care practices within the organizations as well as between the hospitals and community. Some promising practices in this area involved the use of technology to bring specialized expertise to seniors' home communities. The theme of inter-professional teamwork and community partnerships will act as catalysts for enhancing a continuum of care for seniors.

All hospitals reported having programs and processes in place that promote patient centred care and cultural diversity. While all hospitals reported having mechanisms for input from stakeholders, less frequently reported was the application of a seniors lens to these methods. Some promising practices arising from the data analysis involved development of organization-wide educational sessions to sensitize staff to seniors' needs, better communicate with and engage patients and families, and promote a team approach to care. Organization-wide practices are an important feature of a senior friendly culture.

All self assessments reported a move forward in developing policies and procedures to address ethical decision making including accessing the organization's ethicist for care dilemmas, advanced care directives and utilization of capacity assessors. An opportunity to learn from ethical concerns is critical to leveraging best practice knowledge. Ensuring that staff have current knowledge on relevant issues and are familiar with their hospital's approach to ethical concerns will build capacity to manage unique ethical situations sensitively and effectively.

The most frequently cited barrier to senior friendly care was the physical environment. While recognizing that built environment capital and infrastructure improvements are ongoing and undertaken over time, several hospitals pointed to financial constraints in their ability to apply best practices beyond the Access to Ontarians with Disabilities Act (AODA). There is a substantial body of literature regarding senior friendly environmental design which includes principles that go well beyond AODA. Promising practices include the aligning of purchasing practices with the needs of a senior population. It will become increasingly important for staff responsible for capital and infrastructure projects and purchases to have the necessary training

and information available to them to optimize opportunities for the development, maintenance and purchasing operations of the physical environment that meets the needs of seniors and others requiring safe access and manoeuvrability within the built environment.

The Senior Friendly Hospital Framework has not only been a lens through which hospitals have been able to assess their own current progress to date, identify gaps and opportunities for improvement but also as a means of responding to the system pressures they currently face. An organizational culture that promotes and incorporates senior friendly practices and collaborations can significantly contribute to improving access, system integration and capacity building as well as continuing to be a significant partner in allowing older adults to maintain their independent functioning and remain in their homes for as long as possible.

2. The Waterloo Wellington Senior Friendly Hospital Strategy

BACKGROUND

The Waterloo Wellington Local Health Integration Network (WWLHIN) is responsible for planning, coordinating and funding health services in Waterloo Region, Wellington and South Grey County. Its area has a population of more than 730,000 people representing 5.6% of Ontario's total population. The mix of urban and rural areas in the WWLHIN creates significant and unique challenges in providing quality and patient-centred care to an aging population. For example, compared to urban residents, rural residents are hospitalized at higher rates.[1]

As seniors are the primary users of hospital services, systematic changes will be necessary in both hospitals and the broader health system to ensure capacity and sustainability to respond to this elder care need. Most often hospital planning and policy focuses on the consequences of care for older adults and ALC pressures rather than root causes. While the WWLHIN has clearly recognized the significance of timely access to appropriate community and support as a pillar of seniors' health services, their commitment to recognize the hospital experience of older patients as a contributing factor in ALC pressures is commendable. Indeed, the potential to align these strategies to achieve a cumulative outcome affecting both hospital and transitional care for seniors is most significant. Enhancing the care of seniors in hospital to increase their ability to transition home safely from hospital 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 in ALC beds. To guide work on this priority the LHINs across the province have endorsed a Senior Friendly Hospital Strategy developed through the Regional Geriatric Programs of Ontario. The five-domain framework serves as a roadmap to quality improvement, defining key areas for attention in order to optimize the hospital experience and enable positive outcomes for frail seniors. This is an important strategy that will complement and build on existing
hospital efforts and community strategies to help seniors preserve their independence and well-being.

CONTEXT:

The population growth among people age 65+ years in the Waterloo Wellington LHIN is projected to be faster than that of the provincial growth (68.6% vs. 62.8%). The prevalence of dementia in Waterloo Wellington is expected to increase over 28% by 2016 compared to 2008[2] . Increasingly individuals with dementia 65+ will be living in their own homes subsequently increasing the economic burden of care for the community including hospital care[3].

Data from Intellihealth Ontario indicate that 17% of Waterloo Wellington's ED visits are attributable to seniors. In addition, seniors account for 53% of acute hospital days and 71% of acute ALC days in the Waterloo Wellington LHIN. Closer examination of this data reveals age-related use of these services with a higher proportion of hospital days attributable to the 75-84 age group. The older age groups 75-84 and 85+ also account for the highest proportion of ALC days. In contrast the lower proportion of ED visits is attributable to the 85+ years age group compared with the 65-74 and 75-84 age groups (Figure 1).
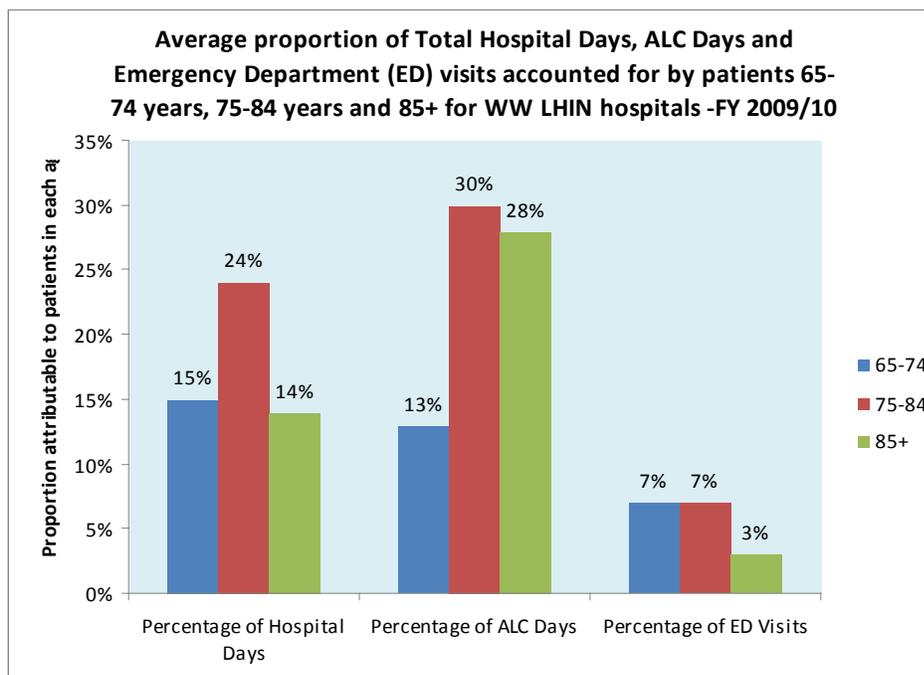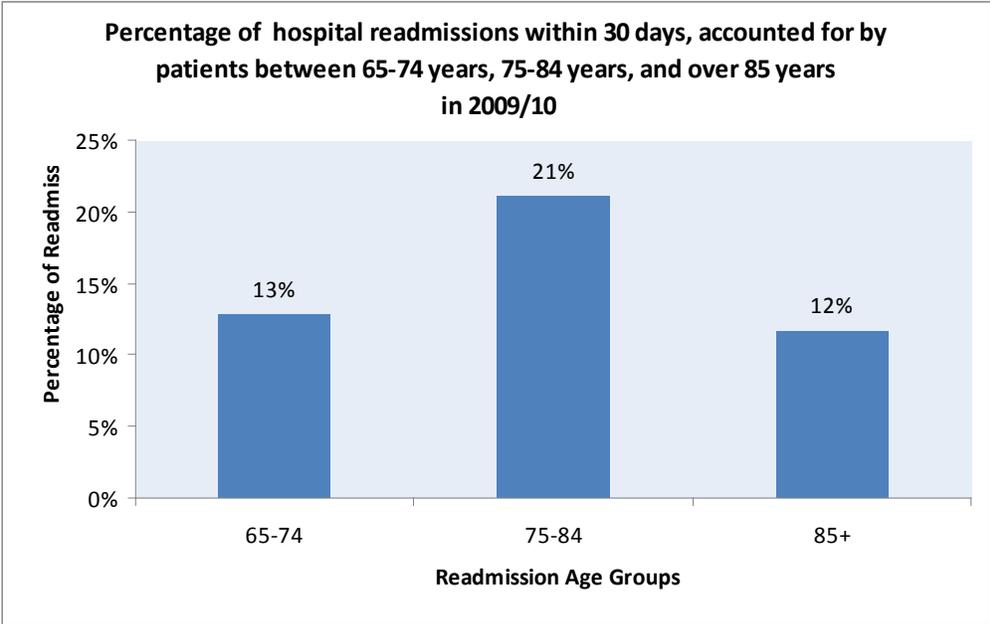
Figure 1

Figure 2 shows the percentage readmission within 30 days and identifies that the 75-84 years age group accounts for the higher percentage readmission within 30 days in 2009/10. A similar pattern is noted the previous 2 years as well. This is significant as appropriate transitional care could reduce this figure substantially. While the number of chronic conditions increases with age, a new study from the Canadian Institute for Health Information (CIHI) cautions using age alone as an indicator of health care service use. Among the study's findings was that seniors (85 and older) with no chronic conditions made less than half the number of health care visits as younger seniors with three or more chronic conditions. In addition seniors with 3 or more chronic conditions made three times as many emergency department visits as seniors with no reported chronic conditions[4]. A substantial body of evidence shows that when seniors are admitted to hospital they experience twice the rate of adverse events than younger age groups including delirium, falls, medication errors, hospital acquired infections and functional decline [5,6] . This would suggest that there are a number of contextual factors to consider including changing demographics, utilization patterns, seniors' baseline vulnerability and precipitating risk factors found in the hospital environment[7]. The pressures existing now in managing hospital length of stay and ALC rates will increase significantly unless mitigating strategies are implemented.

Figure 2

Percentage of hospital readmissions within 30 days, accounted for by patients between 65-74 years, 75-84 years, and over 85 years in 2009/10

The Senior Friendly Hospital Strategy is designed to inform senior leaders in hospitals on how to modify 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. Moreover, a systematic approach to improving hospital processes and environmental issues for seniors will contribute to hospitals' capacity to create a positive, safe patient experience and deliver high quality health care, consistent with the requirements of the Excellent Care for All Act. The Waterloo Wellington LHIN will be stewards and leaders in this systematic alignment of needs and resources by supporting partner hospitals in adopting the Senior Friendly Hospital Framework and integrating measurable objectives into the hospital service accountability agreements.

3. Conceptual Underpinning – The Senior Friendly Framework

The Senior Friendly Hospital Framework describes a comprehensive approach that is to be applied to organizational decision making. Recognizing the complexity of frailty and the vulnerability of seniors to the unintended consequences of hospitalization that may irreversibly compromise their function, well-being, and independence, the senior friendly hospital has 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 Regional Geriatric Programs 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. The care is delivered in a manner that ensures continuity within the health care system and with the community, so that the independence of seniors is preserved.

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

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

5) **Physical Environment –** The hospital's structures, spaces, equipment, and facilities provide an environment which minimizes the vulnerabilities of frail patients, thereby promoting safety, independence, and functional well-being.

This Senior Friendly Hospital Framework provides a common pathway to leverage positive change in any hospital. While all five components of the Senior Friendly Hospital Framework are required for optimal outcomes, it is recognized that a phase-in approach to change may be more feasible and practical in its implementation. The Framework therefore supports the establishment of short, medium and long term change objectives and timelines.

Self-Assessment Process

The first step in the Senior Friendly Strategy is to gain an understanding of the current state or snapshot of senior friendly care in the Waterloo Wellington LHIN. Hospitals across the LHIN completed a self assessment on how senior friendly their hospital is. Questions in the *Self Assessment Template* were structured around the 5-domain Senior Friendly Hospital Framework with the result of gauging each organization's level of commitment, their efforts to

date, as well as their perceived challenges and needs in becoming a senior friendly hospital. This first step in mapping senior friendly efforts proved valuable in identifying common themes and promising practices across the LHIN, as well as some of the challenges in providing optimal care and opportunities for change. Promising Practices identified in the report relate to innovations that are seen as moving the senior friendly strategy forward. Subsequent steps will include focus on implementation of continuous improvement and sustainability plans.

4. Goals of the Self Assessment

- To serve as a summary of the current state of senior friendly care in WWLHIN;
- To acknowledge innovative practices in senior friendly care;
- To identify hospital and system level improvement opportunities;
- To promote knowledge sharing of innovative practices and successes.

Findings and opportunities from the self assessment will contribute to the transformation agenda of the WWLHIN; improve access, improve the health of the population, enhance system effectiveness and build capacity to achieve a sustainable health care system.

5. Methods

In December 2010 each CEO of the eight hospitals received a background document on Senior Friendly Care in Waterloo Wellington LHIN Hospitals as well as a *Self Assessment Template*, both built on the structure of the Regional Geriatric Program's Senior Friendly Hospital Framework. Within 2 months of delivery, self assessments from 6 acute care hospitals, one Rehabilitation/CCC hospital and one mental health hospital were submitted to the WWLHIN. (Figure 3)

Figure 3

Senior Friendly Hospital Strategy Self Assessment: WWLHIN Participating Hospitals		
Acute Care Hospitals	Rehabilitation/CCC Hospitals	Mental Health Hospitals
Cambridge Memorial Hospital Grand River Hospital Guelph General Hospital Groves Memorial Hospital North Wellington Health Care St. Mary's General Hospital	St. Joseph's Health Centre	Homewood Health Centre

Each self-assessment was read and analyzed by three independent reviewers; one clinical resource consultant and 2 geriatrician clinical leads. The descriptive and exploratory nature of this report required predominantly qualitative responses which in turn necessitated subjective interpretation. This called for a measure of familiarity of the system in which the organizations function. The analysis, like the self assessment template, was structured on the Senior Friendly Framework, which facilitated the identification of common themes, promising practices, and opportunities for improvement. Where appropriate the numeric data was aggregated by a staff of the Regional Geriatric Program Central to provide a system view. An advisory group for the Summary Report was struck with membership representing a variety of perspectives including clinical, community, geriatric speciality, academic and executive. Drafts of the Summary Report were reviewed before sending to the LHIN for review.

In addition to the promising practices and opportunities for improvement that this report highlights, each hospital received an individualized feedback letter. This letter has included a summary of the hospital's responses, the aggregate responses of hospitals in their sector and the aggregate responses of all WWLHIN hospitals. The feedback also has highlighted the hospitals' innovative practices and opportunities for improvement in providing Senior Friendly Care in the WWLHIN.

6. Limitations of the Analysis

It is important to note that by its exploratory nature the self-assessment was not developed to perform a detailed environmental scan and therefore the report is not intended to be a comprehensive comparison of all WWLHIN hospital services for seniors. There are also likely areas where services and activities were under-reported. For example where information provided in the self assessment was not detailed enough for analysis, clarification and further information on responses were requested from the participating hospitals. Also considered was the possibility of social desirability bias in completing the assessment however the geriatricians who practice in these hospitals indicated there was minimal evidence of this in the self assessment process. To provide comparison and align aggregated data with other LHIN areas, the mental health hospital was aggregated acute/ other and the Rehabilitation/CCC hospital stood alone in its own category. Further comparison was afforded with all hospitals aggregate data; however there were some limitations to the comparative data given there was only 1 hospital in the Rehab/CCC category. In addition the mental health hospital reported on 1 unit only where older adults are served versus an organization wide lens.

7. Findings

7.1 ORGANIZATIONAL SUPPORT

Thirty-eight percent of hospitals (Figure 4) indicated they have an explicit goal for senior friendly care in their strategic plan. Most hospitals expressed a broad commitment to senior friendly care and reported on specific programs in their organization with a senior friendly focus. Where there were explicit goals for excellence in elder care identified in their strategic plans, more explicit senior friendly practices were in place. The majority of hospitals identified a senior executive as lead for all patient care that includes responsibility for care of seniors. Two sister organizations share a recently appointed corporate Vice President of Elder Care within the health system in which they belong and whose role includes setting direction for Elder Care

in their health system; assessment and implementation of clinical best practices for elder care services across the care continuum and target evidence based improvements. Not all hospitals have adopted enabling structures such as designated committees or explicit board commitment for senior friendly care (Figure 4). Creating an elder friendly hospital culture requires a multi-dimensional and multi-level approach. Given that most hospitals recognized care to seniors as an evolving core business of their organization, there is an opportunity to consider development of committee structures and Board champions for senior friendly care. This commitment in turn would contribute to the development of a more explicit senior friendly strategic direction for organizations. Garnering both administrative and corporate sponsorship is considered vital to the development of a supportive culture that can move senior friendly initiatives forward in the organization[8].

Figure 4*

Response to Organizational Support Questions

Legend:
- Aggregate Acute/Other Hospital Response
- Aggregate Rehab/CCC Hospital Response
- Aggregate All Hospital Response
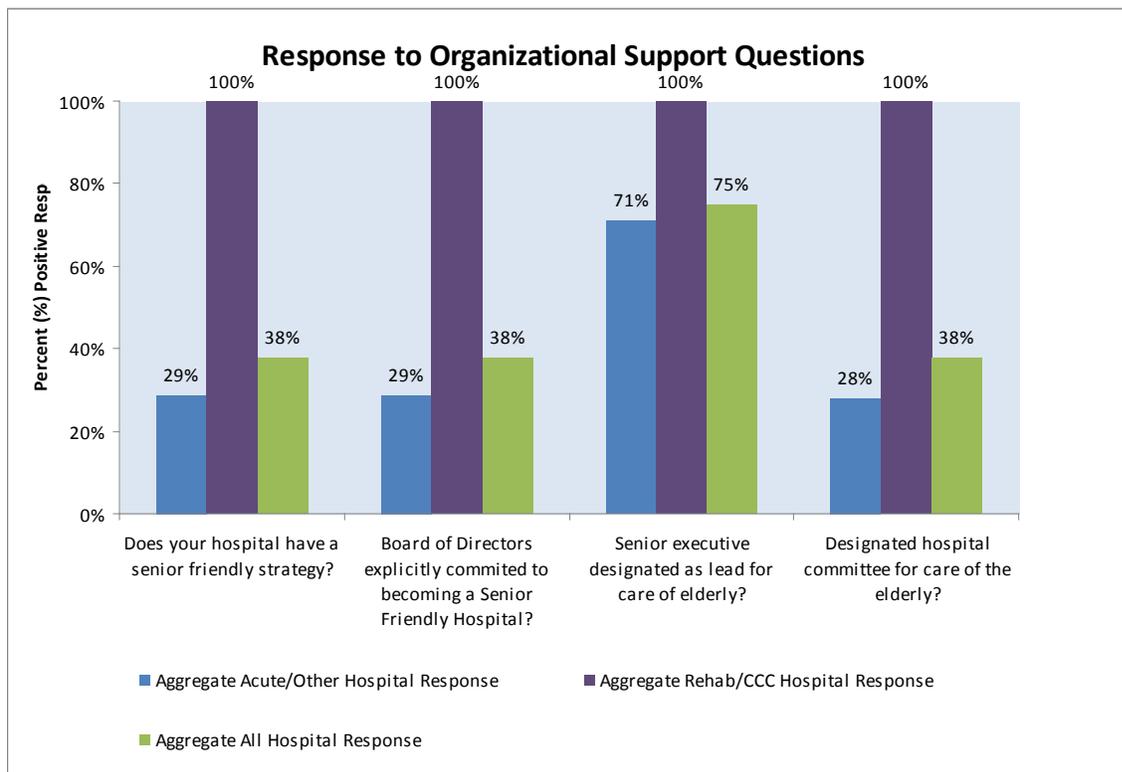
*Note: N =1 for Aggregate Rehab/CCC Hospital

All hospitals expressed an interest in recruiting and developing staff with skill and training in the areas of best practice and geriatric competencies. However, they also expressed some common

challenges such as shortages of staff with specialized training, the need to share FTE's across several clinical areas versus dedicated to one specific clinical program and succession planning issues. Rural differences were also noted with both human resources and financial issues cited for recruitment and staff development. Despite shortages, all acute hospitals have invested in Geriatric Emergency Management (GEM) nurses and leverage this human resource for championing best practice education. A potential advantage of sharing FTE's across clinical areas is their valuable perspective for identifying successes and prospective improvements and standardization to processes of care across clinical programs and organizations. One hospital utilizes in-house expertise across the disciplines and specific programs for resource consultation on patient care issues and program development. While most consultation requests are as required, there is an opportunity here to formalize this process in order to evaluate the strategy's impact on patient care, inter-professional collaboration and process improvements. In order to accomplish however, resources may need to be leveraged in such a way as to protect some of the paid time for capacity building and continuing education. Other strategies that have been implemented include a human resources directed skill gap analysis of the organization's workforce for planning purposes and the broad use of clinical internships as a succession planning strategy.

 The organizational support component of the SFH framework also examines the structures in place to solicit input from seniors, families and other stakeholders. A number of hospitals utilize formal processes to accomplish this and include formal satisfaction surveys, patient and/or family advisory committees and periodic focus groups for specific feedback purposes (Figure 5) However, seniors have not been targeted specifically in the surveys or other feedback mechanisms to date. One hospital is in the process of developing a community engagement process to help define program direction. Two hospitals use their participation in formal networks as a way of soliciting input from community stakeholders and utilizing applicable evaluation information from other programs to assist with defining program direction/ processes. It is evident from the self assessment data that there is a reliance on patient relations (responding to complaints) as the most common form of input from stakeholders. This

is not to negate this form of feedback rather to say that the adoption of structured processes is more significant for the identification of continuous improvements and evaluation with regard to patient and stakeholder satisfaction.

Figure 5

Various Methods Reported by Hospital for Soliciting Input from Older Patients	
Method for Soliciting Input from Older Patients	**Number of Hospitals Reporting Using Method**
Patient Relations	6
Satisfaction Surveys	5
Consultation/Interview	3
Durable Committee Structures	2
Feedback from Partnering Agencies	2
Discharge Phone Call	1

Organizational Support – Promising Practices
Designated corporate executive champion with clearly defined role for seniors care
Targeting of population needs with review of current processes to determine priorities
Skill gap analysis of current workforce for human resources planning
Use of clinical internships as a means of succession planning
Use of participation in Networks to assist with defining program direction and/or processes
Use of in-house expertise across disciplines and programs for consultation on patient care issues and program development

7.2 PROCESSES OF CARE

The *Self Assessment Template* listed a number of clinical areas of risk for hospitalized seniors and asked hospitals whether they have active protocols and/or metrics for care in place in these key clinical areas. Analysis of the submissions also indicated which clinical areas have received more focus compared to others. (Figures 6a, 6b, 6c).

Figure 6 a

Percent of Acute/Other Hospitals with Protocols and Active Monitoring in Place for Confirmed Senior Risk Areas

Figure 6b*

Percent of Rehab/CCC Hospitals with Protocols and Active Monitoring in Place for Confirmed Senior Risk Areas
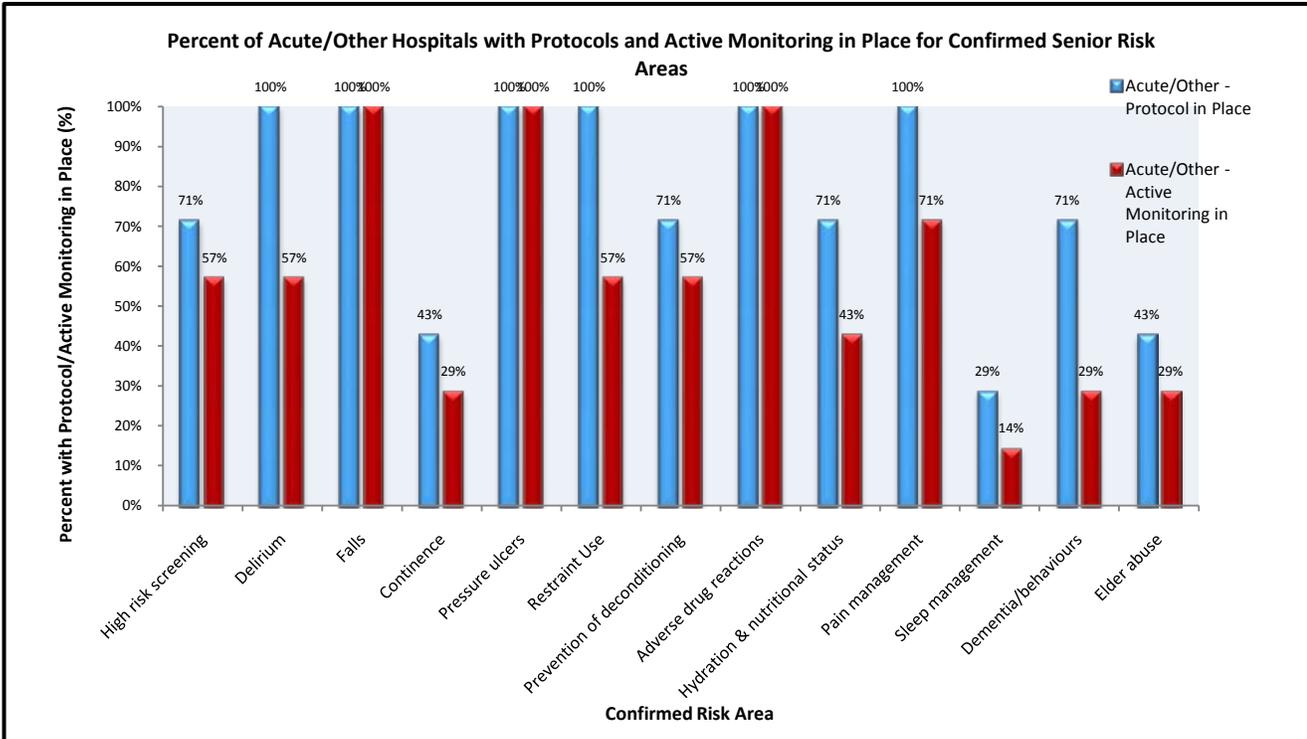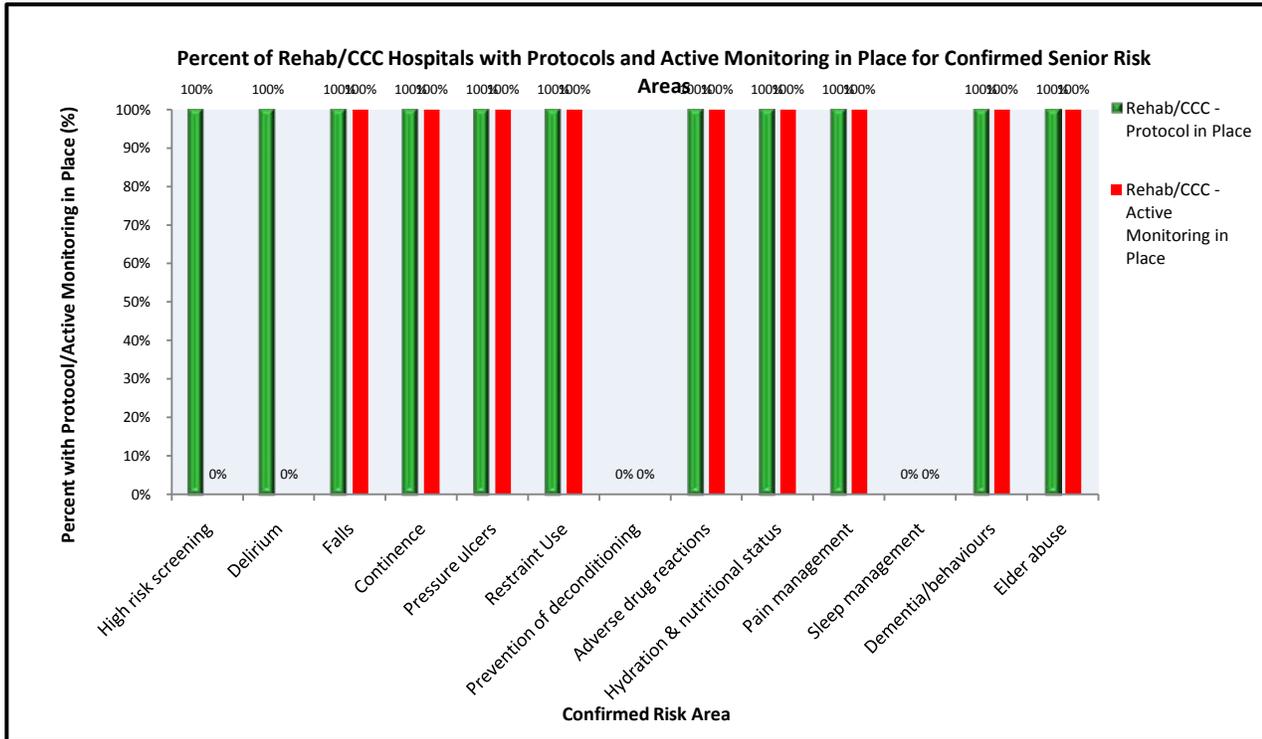
Note: N=1 for Aggregated Rehab/CCC Hospital

Figure 6c

Percent of Hospitals with Protocols and Active Monitoring in Place for Confirmed Senior Risk Areas
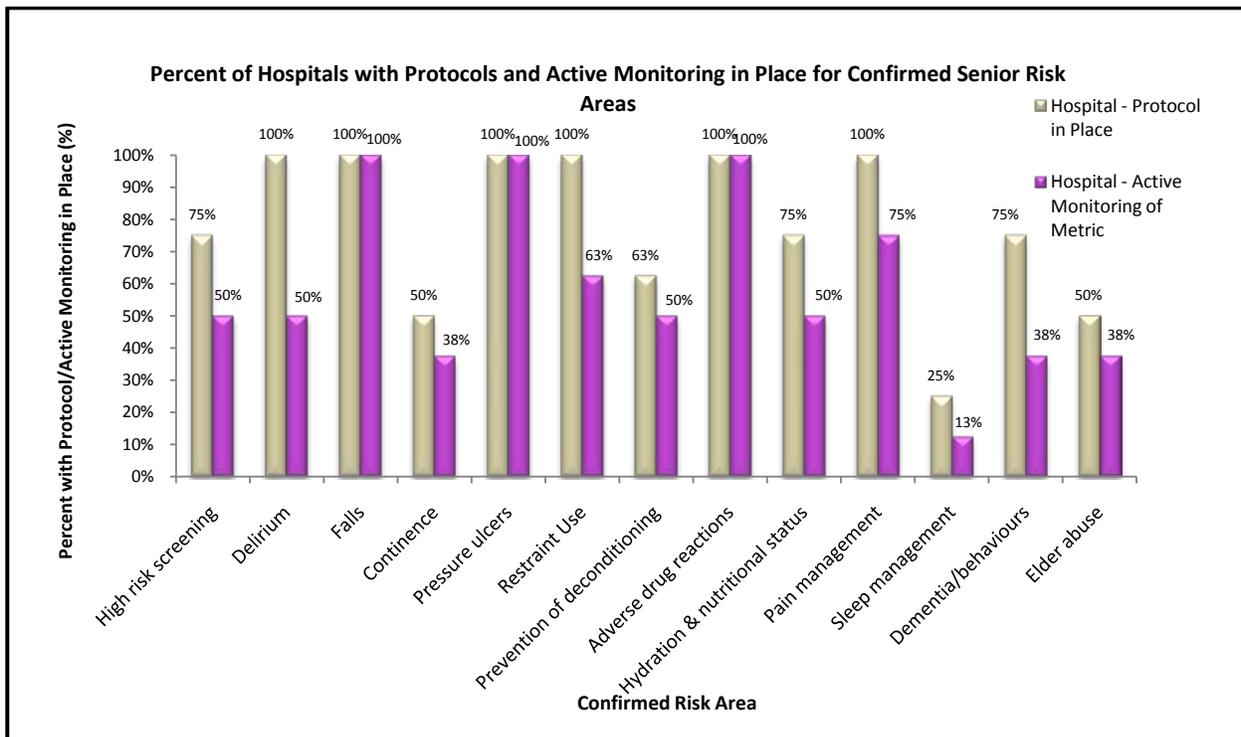
Falls, pressure ulcers, adverse drug reactions, pain management and restraint use are clinical areas that were most frequently given attention of a clinical protocol and procedure for active monitoring. In fact, 100% of WWLHIN hospitals reported having a protocol and metric for falls, pressure ulcers and adverse drug reactions (Figures 6a, 6b, 6c), all three of which are also required organizational practices of Accreditation Canada. However, 50% of hospitals reported an increase in fall rate in 2009/10 over the previous year. A review of the organization's falls prevention program including date developed and last date of staff education may be a start point for improvement opportunities. Encouraging is the trend in protocol development for delirium and hydration/nutritional status. Delirium is a common and serious problem for hospitalized older adults resulting in increased morbidity, mortality, longer and costlier hospital stays and nursing home placement[9]. Poor nutritional status can lead to longer hospital stays, more medical complications and hospital readmissions[10]. A promising practice from one hospital was the assessment of patients with cognitive impairment and risk for developing delirium by a CNS and geriatrician. This resulted in early recognition of risk factors and earlier intervention.

The areas of continence and sleep management were less likely to have protocols and/ or active monitoring activities in place. Both are linked to functional decline in the elderly[11, 12]. A promising practice in one hospital involves the identification of an early mobility lead for programs offered 3 times a week to acute inpatients to prevent deconditioning.

Noted was the variation in how protocols are monitored in that a variety of metrics are used for the same clinical process of care across hospitals. The development of common indicators could enable tracking of improvements across the sector. As well, where protocols were being advanced in several clinical areas, the accompanying development of metrics for the protocols was slower to be developed. Given the high risk nature of these clinical areas, the ability to actively monitor the impact of clinical processes on patient care is critical.

Additional protocols which have been developed by 2 hospitals involve cognitive assessment and Foley catheterization rates. This is commendable given that cognitive impairment can add substantially to patient risk of poor outcomes and, catheterization can, for example, increase risk of nosocomial infection which in turn can increase risk of hospital acquired delirium.

When asked to report on senior friendly care priorities, collaborative, inter-professional care and optimization of clinical processes were the two most frequent themes (Figure 7)

Figure 7

Top 5 Senior Friendly Care Priority Areas *
Collaborative, Inter-professional Care
Optimizing Clinical Processes Composed of: • Functional Decline (5)   • Falls (3)   • Delirium (3)   • Other: Dementia, Skin/Wound Care, Hospital Acquired Health Problems, End of Life, Depression
Physical Environment
Accountability/Metrics
Education/Senior Friendly Culture
* The number in parenthesis indicates the number of hospitals out of 8 total that reported this a priority area

This could suggest that optimization of clinical processes occurs within an environment of collaborative, inter-professional care. Inter-professional collaborative care is becoming a desired means of improving patient outcomes through the optimal contribution of all professionals and the enhancing of patient and family goals and values[13, 14]. While the creation of protocols and active monitoring of clinical processes are important steps, the ongoing evaluation of these processes as they impact patient care and outcomes will be important go forward activities for all hospitals.

Organizations were asked to report on discharge planning and transitional care practices, key features of the processes of care component of senior friendly hospitals. A number of enabling practices were described and cluster around these themes; interdisciplinary involvement in identifying and coordinating needs of patients ready for discharge, initiating discharge planning soon after admission, follow up calls and time limited case management for specific higher risk patients and their families. More emphasis however was placed on the use of partnerships for transitional care of patients being discharged. These included the 'soft hand off' approach to a relatively recently funded Intensive Geriatric Service Program (IGSW) through the Aging at Home Strategy which focuses on assisting patients and families with implementation of hospital care plans in the community; and formal meetings with partners to evaluate effectiveness of patient care as well as of the partnership. For example one hospital meets quarterly with representatives from the LTC community to discuss enablers, barriers and challenges to patient care as well as reviews patient safety and accessibility issues. The IGSW's appear to be a well utilized addition to the system of care, however they do not represent the full 'transitional care' model as best developed by Naylor and Coleman where an advance practice nurse actively assesses the patient and promotes self care. Taking into consideration this clarification, fostering relationships together with regular review of the effectiveness of those relationships as they relate to quality of patient care are key features of senior friendly care. The opportunities created from this investment will strengthen inter-organizational collaboration and ultimately improve system effectiveness in a senior's ability to remain home after discharge.

The self assessment also inquired about senior friendly practices in the Emergency Department (ED). All acute care hospitals reported practices involving access to specialized expertise provided by GEM nurses in the ED. In addition to the GEM nurses whose focus is on ED diversion, referral to geriatrics and/or IGSW's and comprehensive assessment for admitted seniors early in their stay, specialized assessment reported by several hospitals included interdisciplinary involvement by Occupational Therapy, Physiotherapy, Social Work and CCAC case managers. This is commendable given the multi-factorial presentation of frail elderly in the

ED. Of note were rural/urban differences that is, the rural hospital's ability to provide all of these additional types of resources in the ED. Taking advantage of this interdisciplinary approach to patient care in the ED by providing opportunity for inter-professional education and 'cross pollination' of gerontological ideas could strengthen both assessment and discharge practices in the ED.

Other themes include availability of patient information brochures and health teaching by GEM's provided on discharge - for example falls, medications and delirium. A promising practice involves one hospital's implementation of an RPN role in the ED to provide care to patients (many of whom are older) who remain in ED for extended periods waiting for an appropriate bed. This allows for early implementation of care plans and is a commendable practice for transition within setting. Future evaluation of the role would assist with understanding of the impact on patient care and potential uptake by other hospitals. Formal partnership emerged again as a seminal approach to both avoiding ED visits and supported discharge to the community. Avoiding ED visits includes referrals to the LHIN nurse-led outreach team and a promising practice involving GEM nurses' regular contact with retirement homes, the focus of which is building confidence and capacity to divert admission to the ED. With the investment in this partnership, retirement homes view the GEM nurses in this hospital as an alternative source for guidance and support. Follow up contact is also made to ensure the patient's treatment plan is implemented and successful. Supported discharge to the community includes partnerships with a variety of resources including Home First, Home at Last, Easy Coordinated Access and other community service partnerships. Again of note is the role of the Intensive Geriatric Service Worker cited by all hospitals, who provides a timely "soft hand off" approach from the ED to assist patients and families with implementation of the discharge plan and connecting to community services often within the same day of discharge.

Other processes of care themes arising from the analysis include the sharing of geriatrician resources across clinical areas and hospitals and the emerging use of telemedicine in rural areas with the GEM nurses and a geriatrician for patient care. There may be potential for the sharing

of FTE's across clinical areas and organizations for their valuable perspective for identifying successes, prospective improvements and/or standardization to processes of care. Utilization of telemedicine allows the patient access to specialized service and development of a collaborative treatment plan while offering the ability to remain in their home community. Next steps could include the development of measures to assess the impact of these practices on patient care. Included in this development should be the impact of sharing or 'stretching' specialized resources across a large service area.

Of note in the analysis is the focus on best practice guidelines by discipline, the variety of mechanisms used to encourage knowledge transfer such as Best Practice Knowledge Fairs, RNAO BPG Spotlight program, interdisciplinary rounds, lunch and 'interactive blitz' and implementation of best practice initiatives such as Gentle Persuasive Approaches (GPA) and P.I.E.C.E.S. Encouraging also is the use of an interdisciplinary approach to discharge on both in-patient units and in the ED. Next steps could include leveraging interdisciplinary relationships and thereby patient care by providing opportunities for inter-professional education, 'cross pollination' of gerontological ideas across disciplines and clinical areas (when staff are assigned to other work assignments within the hospital) and formalizing collaborative patient centred practices. Parke and Brand[16] identify unit base interdisciplinary working groups as a method of capacity building and sustaining quality improvements[10]. In addition, the consideration of hospital wide working groups as well as unit based working groups support the integration of best practices and quality improvements organization wide. A focus on community partnership relationships to leverage the implementation of the discharge plan was clearly evident across the WWLHIN. Other next steps could include the adoption of a complete transitional care approach to discharge in which advance practice or speciality trained nurses follow patients from hospital to home for extended periods post discharge in order to ensure clinical stability, promote self-care practices among patients and caregivers and impact timely follow up and reassessment by relevant primary and speciality care providers. This consideration is particularly important given the high readmission rates noted earlier in the report.

Processes of Care- Promising Practices
The use of inter-disciplinary practice approaches to processes of care such as discharges from inpatient and ED, and early identification of and early intervention for confirmed senior risk areas act as leverage points for integration of best practices and quality improvements The emphasis on creative intra and inter-organizational roles and partnerships that enhance patient care and build capacity in the community The innovative use of technology (OTN) in rural areas to bring specialized expertise to seniors' home community.

7.3 EMOTIONAL AND BEHAVIOURAL ENVIRONMENT

All hospitals reported having programs and models in place that promote patient-centred care. Fifty percent of all hospitals reported having orientation and education programs with identified learning objectives for seniors' care. Of the 50% with seniors' specific focus, most have embedded seniors care best practice guidelines into clinical modules for new and existing staff.

A promising practice in one organization involves the incorporation of seniors' sensitivity and customer service training, including engagement focused communication skill building with the seniors' population, into all staff orientation. Another hospital has incorporated a seniors' specific education program for staff, Gentle Persuasive Approach as a means to help create an organization-wide senior friendly environment. Targeted to clinical and non-clinical staff, the program increases staff awareness of seniors' needs, the importance of engaging seniors in staff-patient interactions and promotes a team approach to customer service. A senior's experience in the hospital typically involves interaction with clinical and non-clinical staff. Education such as the elder sensitivity training and the senior specific education program mentioned are commendable practices and foster a senior friendly emotional and behavioural environment. Additionally, optimizing the engagement of seniors and staff-patient interactions have been advocated as a means of improving patient outcomes [17.] Moreover, improved outcomes may be achieved by implementing initiatives that sensitize staff to the needs of

seniors and identify mechanisms for maximizing the participation of patients and families in their own care.

Thirty-eight percent of hospitals indicate that they have multiple senior-specific satisfaction measures in their patient satisfaction questionnaires. Fifty percent of hospitals use a formal satisfaction survey with a behaviour-based focus to the interview questions. Potential for stratifying by age and including age-sensitive measures could provide organizations valuable information on their efforts in becoming senior friendly. Additionally, given that care of seniors is an evolving core business of organizations, it would seem prudent to begin to gain an understanding of patient and family satisfaction as it relates to hospital practices and senior-specific quality improvement opportunities.

All hospitals report that they have access to translation services within their organizations. Community resources are also utilized, especially in rural areas. Two hospitals offer culturally sensitive approaches in their spiritual care services and in end-of-life processes of care. One organization offers culturally sensitive recreation programs as well as a diversity and cultural awareness focus for interdisciplinary care planning. Another promising practice reported by one hospital involves the Clinical Nurse Specialist in geriatrics educating volunteers to assist with development of specific program plans for ALC patients. Programs illustrated by these examples contribute to the recognition of the frail elderly as a culturally diverse and heterogeneous population with various needs including multiple chronic conditions and/or cognitive impairment. In addition, strategies such as these provide a broad spectrum of services that address functional, psychological, environmental and spiritual aspects of care developmentally adjusted to account for the special features of aging[18]. Organization-wide practices are important features of a senior friendly culture. Moreover, as previously mentioned, creating a multi-dimensional and multi-level approach to a senior friendly culture involves all staff from the senior levels of leadership including board members to front-line service, support staff and volunteers. The incorporation of age-sensitive patient satisfaction measures into hospital

quality management strategies offers a way to gauge an organization's current efforts in creating a senior friendly culture.

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Emotional and Behavioural Environment – Promising Practices

Seniors sensitivity training and educational initiatives targeted to all staff of an organization.

Development of a cultural awareness focus for interdisciplinary care planning, spiritual care, activities and end-of-life practices

Geriatric resource expertise available for volunteer program development that recognizes the diversity of the frail seniors population

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7.4 ETHICS IN CLINICAL CARE AND RESEARCH

All hospitals across the LHIN reported having access to an ethicist for ethical challenges in health care interactions. Common themes on the types of challenges hospital staff encounter include in order of frequency in which they were reported;

- Capacity assessments – concerns regarding competency in decision-making
- End of life issues
- Substitute Decision Maker issues/conflict
- Balancing Safety/Autonomy in decision making
- Advance Care Directives
- Managing abusive/responsive patients and/or family members

Other issues mentioned less frequently were other abuse concerns and inter-professional decision making.

Fifty percent of organizations indicated that the ethicist may be called by any staff with an ethical concern. Thirty-eight percent of hospitals have policies outlining ethical principles, values, standards of practice and communication with one hospital indicating this document is

posted on each unit. Thirty-eight percent of hospitals also indicated that the ethicist is available and has been accessed for educational rounds and events in addition to meetings regarding ethical concerns. These practices are important for leveraging best practice knowledge in ethics as well as managing ethical issues as they arise. Ensuring that staff knowledge is current and that they are familiar with their hospital's approach to ethical concerns will build capacity to manage unique ethical situations sensitively and effectively.

Ethics in Clinical Care and Research – Promising Practices
Inclusive access to the hospital's ethicist for ethical concerns
Policies that serve as an educative and procedural tool for ethical care and are widely circulated to staff
Access to current best practice education and opportunities for discussion/learning to build capacity to manage ethical concerns sensitively and effectively

7.5 PHYSICAL ENVIRONMENT

When asked to identify barriers to senior friendly care, the most frequently cited response across the Waterloo Wellington LHIN was the hospital physical environment.

While 50% of hospitals reported multiple elements of senior friendly design including reorganization of parking areas to decrease distance from the lot to the building, longer delay automatic doors, minimized paging, voice annunciation in elevators and use of volunteer guides, only one organization had completed an environmental audit that utilizes evidence-based resources. The Code Plus approach developed by Parke and Frieson[19], as well as an extensive literature review of the critical elements of an elder friendly acute hospital undertaken by Gutman[20], identify fundamental principles and considerations for elder friendly design that go beyond the Access to Ontarians with Disabilities Act (AODA). Gutman also suggests there are lessons learned in the design features of the physical environment for individuals with dementia that would be applicable and advantageous for the acute sector to consider. Given that the Waterloo Wellington LHIN will experience an increase in prevalence of dementia of over 28% by 2016 and that increasingly more individuals with dementia will be

living in the community, it would be strongly advisable to review what this literature has to offer in terms of environmental features. Other sources to consider can be found through the Seniors Health Research Network (SHRTN)[21] Communities of Practice (e.g. Designs for Dementia) and the Age Friendly Communities initiative through the University of Waterloo[22] which offers web-based comprehensive best practice based information. One hospital in the LHIN is part of a larger health centre built with new Ministry design standards and could also be a source of information for elder friendly design features.

That is not to say that focus is entirely on special populations rather that design and/or other environmental benefits for a specific population can have relevance for other patient populations whose needs require safe access to and manoeuvrability within the built environment.

Several organizations identified that the self-assessment process had increased their awareness of built environment features as a critical element of a senior friendly hospital. A promising practice noted in the analysis was the trend to align purchasing practices with the needs of seniors. One organization has emphasized the importance of educating and engaging staff in discussions about senior friendly design features. All hospitals recognized that built environment capital and infrastructure improvements are ongoing and undertaken over time. Given the extensive literature available on senior friendly environmental design, and opportunity of involving staff with best practice knowledge on physiological changes with aging, it will become increasingly important that staff responsible for capital and infrastructure projects and purchases have the necessary training and information available to optimize opportunities for the development, maintenance and purchasing operations of the built environment. Consideration for the development of a standard check-list or other tool that is used throughout Waterloo Wellington could also advance senior friendly practices for the physical environment. Additionally, an audit tool adapted from existing guidelines may be a useful tool for administration to improve clinical outcomes and as an educational tool for new staff in a variety of disciplines and program areas[23]

Physical Environment – Promising Practices
The use of evidence based audits to advance senior friendly practices for the built environment
Aligning purchasing practices with the needs of a seniors' patient population
The involvement of staff with specialized expertise and best practice knowledge of physiological changes with aging as resources for future planning for the physical plant and equipment purchases

8. Looking Ahead – Moving toward Senior Friendly Hospital Care in the Waterloo Wellington LHIN

The completion of the self assessments and ensuing analysis of the submissions has provided a snapshot of the current state of senior friendly care in hospitals across the WWLHIN. It has also helped to identify promising practices, key enablers and potential next steps in moving the Senior Friendly Hospital Strategy forward in Waterloo Wellington and across the broader health system.

The process of completing the self assessment alone was reported to benefit hospitals. In several cases, hospitals reported that the completion of the self assessment garnered opportunity to assess their own current progress to date, identify gaps and opportunities for improvement.

Promising practices have been identified at the end of each component section of the document. The following is a summary of key enablers and recommendations arising from the analysis of the self assessment data;

Organizational Support:

Key Enablers:

1. Specific goals for excellence in senior friendly care are identified in strategic plans along with designation of a senior executive specifically responsible for senior friendly care.

2. In-house expertise across disciplines and specific programs are utilized as resource consultants on patient care issues and program development.

Recommendations:

1. Development of committee structures and board champions for senior friendly care. Garnering administrative and corporate sponsorship is considered vital to development of explicit senior friendly supportive organizational culture.

2. Protection of some of the paid time for in-house expertise for capacity building and education be considered.

Processes of Care:

Key Enablers:

1. Regular evaluation of protocols is undertaken.

2. Interdisciplinary involvement is utilized in initiating discharge planning soon after admission.

3. Use of community partnerships for transitional care and early discharge from ED.

4. Utilization of telemedicine for improved access to specialized service and ability of patient to be served in their home community, especially in rural areas.

Recommendations:

1. Recommend regular patient assessment over the course of a hospital stay as it relates to precipitating in-hospital risk factors, especially given expected 28 percent increase in dementia by 2016 in Waterloo Wellington.

2. Develop common indicators for care processes adopted by all hospitals to lend itself to comparative data for quality improvement across the hospital system.

3. Foster inter-professional relationships and community partnerships and include regular review of effectiveness of those relationships as it relates to patient care.

4. Recommend organizational support for collaborative inter-professional practice. Consideration of an administrative lead along with an inter-professional 'geriatrics' steering committee would advance improvements in this area.

5. Develop measures to assess impact of telemedicine on patient care.

Emotional and Behavioural Environment:

Key Enablers:

1. Senior specific sensitivity training and education initiatives that target all staff hospital wide.

2. Optimizing the engagement of seniors and staff-patient interactions as mechanisms for maximizing the participation of patients and families in their own care.

Recommendations:

1. Implement educational initiatives that sensitize all staff to the needs of seniors. Organization wide practices are important features of a senior friendly culture.

2. Incorporate age-sensitive patient satisfaction measures into hospital quality management strategies as a way to gauge current efforts in creating a senior friendly culture.

Ethics in Clinical Care and Research:

Key Enablers:

1. Access to the ethicist by any staff who has an ethical concern.
2. The ethicist is accessed for education and capacity building of staff.

Recommendations:

1. Staff knowledge is current and they are familiar with their hospital's approach to ethical concerns.

Physical Environment:

Key Enablers:

1. The use of evidence-based audits to advance senior friendly practices in the environment.

2. Staff with geriatric expertise are utilized as resource consultants for senior friendly design changes.

Recommendations:
1. Adoption of best practice audit tool or standardized check-list that is used across hospital system to evaluate the physical environment.

2. Staff who are responsible for capital and infrastructure projects and purchases have the necessary training and information available to optimize opportunities for the development, maintenance and purchasing operations of the physical environment.

3. Given that Waterloo Wellington LHIN will experience an increase in prevalence of dementia of over 28% by 2016, recommend design features in the best practice literature on dementia are considered for infrastructure projects.

Two primary themes emerge from the self assessment data with respect to specific actions that the WWLHIN and hospitals should consider in order to ensure a system-wide approach to improving senior friendly care. Those themes are focused funding to assist with implementation of the Hospital Elder Life Program (HELP) and transitional care for high risk seniors. In a study in which the HELP program was successfully replicated in a community teaching hospital the financial return, estimated more than $7.3 million per year, comprised cost savings from delirium prevention and revenue generated from shorter length of stays of HELP patients.[23] The program provides skilled interdisciplinary staff and trained volunteers to conduct intervention protocols targeted toward six delirium risk factors: orientation, therapeutic activities, early mobilization, vision and hearing protocols, oral volume repletion and sleep enhancement. Interestingly, single elements of this program have been reported by some hospitals in their self assessments.

Transitional care of high risk patients on discharge and between settings suggested in the self assessments relates to the increased vulnerability of re-admission and seniors who require more continuous management of their complex care needs in order to remain in the community.[24] Components of successful transitional care programs include i) specialized nurse assessment of patients in hospital and at home after discharge for at least 1 month and up to 3 months; ii) medication reconciliation and management; iii) patient self care training to promote

timely recognition of illness decompensation, implement measures to prevent further decompensation and evaluating the effectiveness of these measures; iv) improving system navigation to promote timely access to outpatient services. Transitional care programs based on these principles have been shown to reduce readmission rates for up to 12 months after discharge and are cost effective.[25,26,27] Although likely beneficial the IGSW program only addresses the issue of system navigation. E-solutions for information transfer to support those transitions would be a component versus a core feature of these interventions. The findings of self assessments did reveal high rates of readmissions for the 75-84 age group. Reducing these rates would be desirable for patients and systems. Typically those over 75 years have complex acute and chronic medical conditions, functional disabilities and often an over extended social network [28]. As these characteristics can lead to increased use of medical resources, in particular, hospital resources, it would be advisable to consider fully implementing transitional care interventions.

Specific indicators recommended for inclusion in the hospital accountability agreements related to senior friendly care also clustered around themes and include; ED LOS by age; ALC days by age group, readmission rates by age (in particular >75years of age), and recognition of functional decline with 'stretcher time' for the elderly. Caution is however suggested with statistics alone, particularly for ED as meaningful indicators for accountability agreements given the potential for example to utilize bed spacing as a response to reduce ED LOS.

The Senior Friendly Hospital Framework has not only been a lens through which hospitals have been able to assess their own current progress to date, identify gaps and opportunities for improvement but also as a preliminary means of responding to the system pressures they currently face. An organizational culture that promotes and incorporates senior friendly practices and collaborations can significantly contribute to improving access, system integration and capacity building as well as continuing to be a significant partner in allowing older adults to maintain their independent functioning and remain in their homes for as long as possible. Changing hospital systems to become senior friendly requires corporate commitment and

implementation of evidence-based strategies that have been shown to improve patient outcomes and reduce the costs associated with health service utilization. By applying the Senior Friendly Hospital Framework to organizational processes, hospitals in the WWLHIN can achieve meaningful improvements in the care of the seniors patients they serve.

9. Highlights of Innovations Across the WWLHIN

Organizational Support:
Corporate System Vice President for Elder Care (St. Joseph's Health Centre, St. Mary's General Hospital) with role of; assessment and implementation of best practices for elder care services across the continuum, setting direction for Elder Care in their health care system, target evidence based improvements –
Enhanced Living Model(ELM)(St. Joseph's Health Centre) – promotes understanding of whole person, focuses on choice, patient participation in planning daily activities, patient and family engagement

Organization Wide Education:
Gentle Persuasive Approaches (GPA) – (Grand River Hospital, Homewood Health Centre, St. Joseph's Health Centre)
Elder Sensitivity Training Orientation – (St. Joseph's Health Centre)

Health and Human Resources
Human Resources Skills Gap Analysis (Grand River Hospital)

Processes of Care:
RNAO BPG Spotlight Program(Cambridge Memorial Hospital, Grand River Hospital)
RPN role in ED (Grand River Hospital) – early implementation of care plans for patients waiting in ED for admission
Skin Wound Assessment Treatment Team (SWATT – Guelph General Hospital)
Fracture Hip Pathway (Guelph General Hospital, St. Joseph's Health Centre)
Falls Prevention Improvement Project – (Guelph General Hospital)
Early mobility lead to prevent deconditioning – (Cambridge Memorial Hospital)
GEM/Nurse Led Outreach/Retirement Homes (Cambridge Memorial Hospital) – regular discussion, consultation to build capacity- facilitates discharges, avoids recidivism
High Risk Behaviour Protocol(St Joseph's Health Centre) – collaborative interdisciplinary and family-engaged approach to high risk patients; includes identification at admission and throughout stay
Falls Program (St. Mary's) CNS consulted on every fall with referral to geriatrician and falls clinic-includes early recognition and treatment for delirium

<u>Creative Partnerships:</u>
Coordinated discharge from ED and inpatient utilizing CNS,GEM nurses OT,PT,SW,CCAC – (Cambridge Memorial Hospital, Grand River Hospital, Guelph General Hospital, St. Mary's Hospital)
Quarterly Partnership Meetings with LTC/Retirement Homes (Guelph General) – focus on successes, barriers, patient safety, accessibility
ALC Volunteer Program (St Mary's General Hospital) specialized geriatric expertise assists volunteer program development with ALC patients
Partnership with Legion for transportation patient transport home from ED – (North Wellington Health Care, Groves Memorial Hospital)

<u>Specialized Units and Programs:</u>
Falls Prevention Clinics (St .Joseph's Health Centre, St. Mary's General Hospital)
Seniors Specialized Mental Health – (Cambridge Memorial Hospital, Grand River Hospital) – consultation and education across community
Geriatric Consultation Clinics – Cambridge Memorial Hospital, Grand River Hospital, St Joseph's Hospital, St. Mary's Hospital)
Geriatric Mental Health Consultation Clinic (St Joseph's Health Centre) – partnership with community geriatric psychiatrist and local mental health agency
Acute Geriatric Clinic (St. Mary's Hospital) outpatient clinic for clients >65 who need to be seen urgently (within one working week) by specialized expertise
Aging Brain Clinic (St Mary's Hospital) – outpatient clinic with focus on cognitive decline and management of BPSD
Geriatric Assessment Unit (GAU – Grand River Hospital) specialized assessment unit designed to optimize the frail seniors' independence – target length of stay is <30 days
Geriatric Rehab Clinic (Grand River Hospital) time limited therapy provide to frail seniors following discharge from inpatient and/or experiencing age-related challenges impacting their independence with ADL's
Specialized MH assessment unit (Program for Older Adults, Homewood Health Centre)

<u>Innovative Use of Technology:</u>
OTN for access to geriatric specialist for rural patients (Groves Memorial Hospital, North Wellington Health Care, St. Joseph's Health Centre) GEM Nurses work with community geriatrician to offer assessment and treatment planning for patients living in rural Wellington
Automated referral process to APN geriatrics (Guelph General Hospital)

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Appendix 1: Participating Members for Completion of Self Assessment

Grand River Hospital
1. Dr George Heckman, Geriatrician and Medical Director CCC and Rehab
2. Dr Denise Wren, Medical Director and Chief of Medicine
3. Dr Shazad Bhatty, Chief of CCC and Rehab programs
4. Susan Edgar, CNS Geriatrics
5. Nancy Pearce, CNS Gerontology CCC
6. Hermine Brown, CNS Surgery
7. Valerie Johnston-Warren, CNS Mental Health
8. Emily Parsons, GEM nurse CNS Emergency
9. Heather Camrass, Program Director Medicine
10. Andrew Palmer, Mental Health
11. Karen Conway, Program Director CCC and Rehab
12. Mark Berry , AVP Cancer Care
13. Joy Bevan, AVP Medicine Services
14. Catherine Lindsay, Decision Support
15. Blondina Matheson, Corporate Director, Planning, Development & Facility Redesign
16. Brenda Vollmer, Corporate Director, Capital Planning & Development
17. Mary Beth MacDonald, Patient Relations
18. Gerard Reuss, Quality
19. Roger Hollis
20. Kevin Wilson

Cambridge Memorial Hospital
1. Susan Gregoroff, VP Clinical Programs & CNE
2. Rita Sharratt, Director Patient Services
3. Charlie Bauman, Manager Oncology/Rehabilitation/Palliative
4. Lorna Zubrickas, Clinical Educator
5. Nisha Walibhai, Manager Informatics
6. Maria Boyes, CNS, WWGEM Resource Consultant
7. Rosemary Lywood, Clinical Educator
8. Dr. J. Yang Geriatrician
9. Lina Johnson, Director Quality and Decision Support
10. Andrew Quayle, Decision Support Analyst

St. Mary's General Hospital
1. Sandra Hett, V.P. Patient Services & CNE
2. Jayne Menard, Program Director
3. Cathy Hurley, Program Manager
4. Susan Oates, CNS Geriatrics
5. Helen Jarman, NP Geriatrics
6. Terry Boshart, Manager Professional Practice and Patient Safety Officer
7. GEM Nurses – Nancy McGuire and Mary Ostrowski

Groves Memorial Hospital
1. Diane Wilkinson, VP Clinical Services & CNE

2. Lisette Columbus
3. Wilma Kassian

North Wellington Health Care
1. Diane Wilkinson, VP Clinical Services & CNE
2. Angela Stanley
3. Wilma Kassian

Homewood Health Centre
1. Karen Keleher

St. Josephs Health Centre

1. Terrie Dean, Senior Director CCC, Rehabilitation, Ambulatory Care
2. Julie Reid, Coordinator Quality Risk and Patient Safety
3. Wayne Lew, Manager Outpatient Rehabilitation
4. Paula Smyth, Manager CCC
5. Matt Smith, Manager Rehabilitation, Ambulatory Care
6. Kathy Tschirhart, VP Clinical Services CNE

Guelph General Hospital

1. Eileen Bain, Vice President, Patient Services, CNE
2. Cheryl Cowden, Decision Support
3. Kim Crawford, Clinical Educator, NP
4. Michelle DaGLoria, Clinical Educator, PPL/Surg/Med
5. Wendy Furness, CNS
6. Janice Macdonald, Social Worker
7. Deborah Monahan, GEM Nurse, CNS
8. Kay Snowe, Director, Medicine

Appendix 2: WWLHIN Senior Friendly Hospital Advisory Group

Marianne Walker
President, St. Joseph's Health Centre Guelph
Co-Chair Senior Friendly Advisory Group

Dr. Sharon Marr, MD FRCPC,
Division Director Geriatric Medicine and Associate Professor McMaster University
Chair, Regional Geriatric Program Central
Co-Chair Senior Friendly Advisory Group

David Jewell
Director, Regional Geriatric Program Central

Dr. Amra Noor MD FRCPC
Clinical Lead Senior Friendly Advisory Group

Dr. Gagan Sarkaria MD FRCPC
Clinical Lead, Senior Friendly Advisory Group

Dr. George Heckman MD FRCPC
Geriatrician Lead, Waterloo Wellington LHIN

Dr. John Yang MD FRCPC
Geriatrician, Cambridge Memorial Hosptial

Diane Wilkinson
VP Clinical Services & Chief Nursing Officer
North Wellington Health Care, Groves Memorial Hospital

Jane McKinnon Wilson
Waterloo Wellington Geriatric System Coordinator

Helen Jarman
Nurse Practitioner, Geriatrics
St. Mary's Hospital

Maria Boyes
Clinical Nurse Specialist
Cambridge Memorial Hospital
WWGEM Resource Consultant

Susan Edgar
Clinical Nurse Specialist
Grand River Hospital

Barbara McKay
Director, Client Services
Waterloo Wellington CCAC

Cathy Sturdy Smith
Clinical Consultant
Senior Friendly Hospital Advisory Group

Gloria Whitson-Shea
Clinical Lead
Waterlooo Wellington LHIN

Appendix 3: Self Assessment Aggregate Reponses

Self-Assessment Question	Aggregate Rehab/CCC Hospital Response	Aggregate Acute/Other Hospital Response	Aggregate All Hospital Response[1]
A1. Does your hospital have a senior's friendly strategy?	100% Yes	29% Yes	38% Yes
C1.1. Has the Board of Directors made an explicit commitment to become a Senior Friendly Hospital?	100% Yes	29% Yes	38% Yes
C1.2. Has a senior executive been designated as the organizational lead for geriatric/care of the elderly initiatives?	100% Yes	71% Yes	75% Yes
C1.4. Do you have a designated hospital committee for care of the elderly? (does not include committees for a specific senior friendly initiative)	100%Yes	14% Yes	26% Yes
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?	77% of protocols and metrics are in place for confirmed senior risk areas	67% of protocols and metrics are in place for confirmed senior risk areas	68% of protocols and metrics are in place for confirmed senior risk areas
C3.2. Are age-sensitive patient satisfaction measures incorporated into hospital quality management strategies?	100% Yes	29% Yes	38% Yes
C3.3. What programs and processes do you have in place to help older patients feel informed and involved about decision affecting their care?	100% Yes, in place	43% Yes, in place	50%, Yes, in place
C3.4. What programs and processes do you have in place to support cultural diversity among seniors and their families?	100% Yes, in place	29% Yes, in place	38% Yes, in place
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?	100% Yes, in place	71% Yes, in place	75% Yes, in place
C4.1. Does your staff have access to an ethicist to advise on ethical issues related to care of older patients?	100% Yes	100% Yes	100% Yes
C4.2 Does your hospital have a specific policy on Advance Care Directives?	100% Yes	100% Yes	100% Yes
C5.2. Has your hospital conducted any senior friendly environmental audits of physical space using peer-reviewed guidelines (e.g. RGP audit, CodePlus or other)?	100% Yes	0% Yes	12.5% Yes

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[1] All Hospital includes rehabilitation, complex continuing care, acute and mental health hospitals