

# It's time to change the way care is provided in hospital for older adults with frailty

## Why senior friendly care (sfCare) is important for your hospital

Hospitals are now addressing backlogs of elective surgeries and medical admissions for older adults with conditions that were exacerbated during the COVID-19 pandemic. Along with ensuring equitable access to care, optimizing patient flow will be especially important at this time.

**Preventing hospital-acquired harm and disability in older adults will be key to reducing lengths of stay (LOS) and alternate levels of care (ALC), and will require the restoration of senior friendly principles as part of the new normal.**

This document is intended to guide hospital leaders in the steps they need to take to embed sfCare within their organization.

sfCare is preventive and proactive care for the unique needs of older adults.

It is not an add-on to care; it is essential care that should be provided at all times, including and especially during a pandemic. It can mean the difference between an older adult with frailty being discharged home quickly after an acute illness or suffering from hospital-acquired harm which results in a designation of ALC and long-term care (LTC) placement.

## Compromised care has contributed to compromised patient flow pre- and post-pandemic

Long before the COVID-19 pandemic, many hospitals were over capacity and grappling with increased lengths of stay (LOS) and ALC numbers. The causes were often identified as capacity issues in other parts of the healthcare system, “not enough home care” and “not enough LTC beds”. However, **hospitals were less likely to recognize how their care processes may have contributed to these issues.** Functional decline and delirium have been widespread in hospitals and have been identified globally as concerns. **Before COVID-19, up to 50% of older adults experienced functional decline during hospitalization that was largely independent of their presenting medical illness.**<sup>1,2,3</sup>

In the COVID-19 pandemic to date, older adults have suffered disproportionately with increased mortality and morbidity. Many are now suffering from social isolation and deconditioning due to a lack of proactive and preventive care. Infection prevention and control (IPAC) measures such as: the restrictions on caregivers, family and volunteers; a decrease in face-to-face interactions with healthcare providers; frequent relocation of patients in hospital; and the wearing of personal protective equipment (PPE) contributed to an increase risk of preventable complications for older adults such as delirium and deconditioning when senior friendly approaches were compromised. **Globally, clinicians are reporting a rise in delirium of up to 70% because of Covid-19.**<sup>4</sup>

### Evidence supports sfCare

Evidence shows that prioritizing senior friendly processes of care such as delirium prevention and early mobilization prevents hospital-acquired harm. Not doing so directly contributes to LOS and ALC.

**Mobilization – A lack of mobilization can lead to hospital-acquired harm for older adults which can result in poor outcomes including mortality, yet many hospitals do not hold providers accountable for mobilization. This is in your power to change.**

**Older hospitalized patients spend most of their time (up to 83%) lying in bed even when they are able to walk independently.**<sup>5</sup> Many hospitals do not prioritize mobilization as an integral part of care, despite the evidence of increased risks of morbidity and mortality associated with deconditioning. Mobilization should have the structure of accountability associated with other care processes, such as medication administration. Lack of mobilization and its resulting complications should be recognized as a hospital-acquired harm.

**Actively facilitating mobilization by encouraging activities of daily living, physical activity, and self-care has proven to be effective in preventing avoidable functional decline in hospitalized older people.**<sup>6</sup>

Positive outcomes of multi-component interventions studied in academic and community hospitals include improved performance of ADLs, improved patient and provider satisfaction, decreased length of stay, decreased rates of discharge to long-term care homes, and lower overall hospital costs<sup>7-10</sup>

**Delirium – Delirium is a preventable medical emergency which leads to increased risk of morbidity and mortality, yet many hospitals do not have reliable and consistent prevention measures in place. Delirium is hospital-acquired harm. This is in your power to change.**

Delirium is common in older adults - **up to 75% of older adults experience delirium after acute illness or surgery**<sup>11</sup>, yet data in many hospitals are limited due to delirium being underdiagnosed or misdiagnosed as a result of limited staff knowledge.<sup>12,13</sup> Many hospitals have not prioritized delirium screening and prevention as an integral part of care despite the evidence of increased risks of morbidity and mortality.

Unmanaged delirium can lead to dire consequences including functional decline, long-term cognitive deterioration, post-operative complications, increased LOS, increased need for admission to LTC, increased health care costs and increased mortality.<sup>14-18</sup> **All high-risk patients, including adults over 65, should receive evidence-based multicomponent delirium prevention strategies delivered by an inter-professional team.**<sup>19,20</sup>

### 6 recommendations for hospital senior leaders

Now is the right time to seize the opportunity to re-imagine and purposefully re-design healthcare systems with sfCare firmly embedded in it. Implementation of sfCare leads to improved patient quality of care and outcomes, and reduction in LOS and ALC.

01

**Acknowledge functional decline and delirium as preventable harms.** Identify opportunities to prevent functional decline and delirium that are under your direct control. This includes basic and essential care delivered by hospital staff, and restoration of quality care where it has been or is at risk of being compromised due to IPAC measures.

02

**Endorse and support sfCare as an organizational priority by creating culture change and accountability.** At the hospital executive level, establish sfCare leadership to guide and implement change. Empower and enable your clinical champions. In the Toronto region, you may have one or more representatives who participate in the Toronto Academic Health Science Network (TAHSN)-Regional Geriatric Program of Toronto Senior Friendly Community of Practice.

03

**Build capacity for all staff and volunteers** so that they are proficient in the provision of sfCare, especially around mobilization and delirium prevention. Provision of care for older patients in a hospital setting is often characterized by inadequate knowledge and awareness of special geriatric needs, and often the knowledge is not integrated into the daily practice of the healthcare team.<sup>5</sup> Resources: [sfCare Learning Series](#) (ready-to-use training modules for clinicians and non-clinical care providers) and [RGP's COVID-19 resources](#). (ready-to-use tools for sfCare in a pandemic).

04

**Engage older adults and caregivers as partners.** Provide information on mobilization and delirium prevention to support older adults and caregivers as active partners in the prevention of functional decline. Resources: [sfCare Learning Series](#), [RGP's COVID-19 resources](#) (ready-to-use education materials for clinicians to share with older adults and caregivers) and [Senior Friendly 7 Toolkit](#).

05

**Safeguard decision-making processes from ageism.** Include someone with expertise in sfCare when decisions are made around access to care during the reopening phases and when implementing new IPAC policies such as those regarding visitors. Leverage your sfCare leaders to apply a senior friendly lens to IPAC policy changes and to ensure that counter measures are put in place where possible in order to mitigate unintended harm.

06

**Use sfCare to optimize the patient journey.** What happens to an older patient in hospital has a pivotal impact on their outcomes and their healthcare journey. Now is the time to amplify delivery of sfCare across the continuum and ensure that it becomes part of the new normal. Whether in Ontario Health Teams or other integrated care approaches, all organizations need to collaborate on sfCare. Resources: [Getting Started with sfCare Roadmap](#).

1. Covinsky KE, RM Palmer, RH Fortinsky, SR Counsell, AL Stewart, D Kresevic, CJ Burant, and CS Landefeld (2003). Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age. *Journal of the American Geriatrics Society* 51(4): 451-458.
2. Sager MA, T Franke, SK Inouye, CS Landefeld, TM Morgan, MA Rudberg, H Sebens, and CH Winograd (1996). Functional outcomes of acute medical illness and hospitalization in older persons. *Archives of Internal Medicine* 156(6): 645-652.
3. Gill TM, HG Allore, TR Holford, and Z Guo (2004). Hospitalization, restricted activity, and the development of disability among older persons. *Journal of the American Medical Association* 292(17): 2115-2124.
4. Helms J, Kremer S, Merdji H, et al. Neurologic Features in Severe SARS-CoV-2 Infection. *N Engl J Med*. 2020 Jun 4;382(23):2268-2270. doi: 10.1056/NEJMc2008597. Epub 2020 Apr 15.
5. Brown CJ, Redden DT, Flood KL, Allman RM. The underrecognized epidemic of low mobility during hospitalization of older adults. *J Am Geriatr Soc*. 2009;57(9):1660-5.
6. Admi, H., Shadmi, E., Baruch, H., & Zisberg, A. (2015). From research to reality: minimizing the effects of hospitalization on older adults. *Rambam Maimonides medical journal*, 6(2), e0017. <https://doi.org/10.5041/RMMJ.10201>.
7. Landefeld CS, RM Palmer, DM Kresevic, RH Fortinsky, and J Kowal (1995). A randomized trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. *New England Journal of Medicine* 332(20): 1338-1344.
8. Counsell SR, CM Holder, LL Liebenauer, RM Palmer, RH Fortinsky, DM Kresevic, LM Quinn, KR Allen, KE Covinsky, and CS Landefeld (2000). Effects of a multicomponent intervention on functional outcomes and process of care in hospitalized older patients: a randomized controlled trail of Acute Care for Elders (ACE) in a community hospital. *Journal of the American Geriatrics Society* 48(12): 1572-1581.
9. de Morton N, JL Keating, and K Jeffs (2007). Exercise for acutely hospitalized older medical patients. *Cochrane Database of Systematic Reviews*, Issue 1. Art No: CD005955. DOI: 10.1002/14651858.CD005955.pub2.
10. Padula CA, C Hughes, and L Baumhover (2009). Impact of a Nurse-Driven Mobility Protocol on Functional Decline in Hospitalized Older Adults. *Journal of Nursing Care Quality* 24(4): 325-331.
11. Inouye SK, Westendorp RG, Saczynski JS, Kimchi EY, Cleinman AA. Delirium in elderly people--authors'reply. *Lancet*. 2014;383(9934):2045.
12. Elie M, F Rousseau, M Cole, F Primeau, J McCusker, and F Bellavance (2000). Prevalence and detection of delirium in elderly emergency department patients. *Canadian Medical Association Journal* 163: 977-981.
13. Hustey FM, and SW Meldon (2002). The prevalence and documentation of impaired mental status in elderly emergency department patients. *Annals of Emergency Medicine* 39: 248-253.
14. Fann, JR (2000). The epidemiology of delirium: A review of studies and methodological issues. *Seminars in Clinical Neuropsychiatry* 5: 64-74.
15. Ely, EW, A Shintani, B Truman, T Speroff, SM Gordon, FE Harrell Jr, SK Inouye, GR Bernard, and RS Dittus (2004). Delirium as a predictor of mortality in mechanically ventilated patients in the intensive care unit. *Journal of the American Medical Association* 291(14): 1753-1762.
16. McCusker, J, M Cole, N Dendukuri, E Belzile, and F Primeau (2001). Delirium in older medical inpatients and subsequent cognitive and functional status: a prospective study. *Canadian Medical Association Journal* 165: 575-583.
17. Pompei, P, M Foreman, MA Rudberg, SK Inouye, V Braund, and CK Cassel (1994). Delirium in hospitalized older persons: outcomes and predictors. *Journal of the American Geriatrics Society* 42: 809-815.
18. Inouye, SK (2006). Delirium in older persons. *New England Journal of Medicine* 354: 1157-1165.
19. Inouye SK, ST Bogardus Jr, DI Baker, L Leo-Summers, and LM Cooney Jr (2000). The Hospital Elder Life Program: a model of care to prevent cognitive and functional decline in older hospitalized patients. *Journal of the American Geriatrics Society* 48: 1679-1706.
20. Hosker Christian, Ward David. Hypoactive delirium *BMJ* 2017; 357 :j2047.