The Ontario Senior Friendly Hospital Strategy:
Overview and Implementation of Indicators to Monitor Hospital-acquired Delirium and Functional Decline

33rd Annual Scientific Meeting of the Canadian Geriatrics Society
Senior Friendly Hospitals Workshop, April 20 2013

Ken Wong
Regional Geriatric Program of Toronto
Major Components of Ontario Health Care Spending 2010-11

- Hospitals $15.53B (35%)
- Doctors and other Practitioners $11.91B (27%)
- Prescriptions $3.45B (7.7%)
- Long Term Care $3.44B (7.7%)
- Community Care $2.66B (6%)
- Other $7.76B (17.3%)

Source: Ontario MOHLTC and MHP

Context

Older Adults in Ontario
- 14.6% of population
- 20% of emergency dept visits
- 40.4% of all hospitalizations
- 58.8% of hospital days

(Ontario MOHLTC 2012)
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
The Ontario Senior Friendly Hospital Strategy

PHASE 1
Objective
• Identify current state
Plan
• Hospital self-assessments
• LHIN-level roll-up
• Provincial roll-up

PHASE 2
Objective
• Close the gap
Plan
• Implement hospital improvement plans
• Develop key enablers

PHASE 3 - ONGOING
Objective
• Monitor and sustain hospital and system improvements

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

Provincial Summary Report
SFH “Promising Practices” Toolkit

SFH Indicators
Provincial Summary of SFH Care

• a collaboration of all LHINs (14) and Regional Geriatric Programs (6) in Ontario

• a snapshot of SFH care across 155 Ontario hospitals

• identifies promising practices – these helped inform recommendations for SFH care

• identifies priority areas for action
Organizational Support

Processes of Care

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**KEY FINDINGS:**
- 39% – strategic plan commitments
- 30% – board commitment
- 31% – hospital committee for care of elderly
- 55% – geriatrics education for staff

**RECOMMENDATIONS:**
1. Establish board and/or strategic planning commitments for a Senior Friendly Hospital
2. Designate a hospital lead for SFH initiatives
3. Train/empower clinical geriatrics champions
4. Develop human resources via seniors-focused skills development
KEY FINDINGS:
Frequent protocols and monitoring for:
- falls
- pressure ulcers
- adverse drug reactions

Infrequent protocols and monitoring for:
- sleep
- continence
- hydration/nutrition
- responsive behaviours
- functional decline
- delirium

RECOMMENDATIONS:
1. Implement inter-professional protocols across hospital to optimize the physical, cognitive, and psychosocial function of older patients
2. Support transitions in care by promoting inter-organizational collaboration
KEY FINDINGS:
28% – age sensitive considerations in patient satisfaction/quality improvement strategies

RECOMMENDATIONS:
1. Provide all staff – clinical and non-clinical – with seniors sensitivity training to promote a senior friendly organizational culture
2. Apply a senior-friendly lens to quality improvement (e.g. patient-centred care and diversity practices)
Organizational Support

Processes of Care

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Ethics in Clinical Care & Research

Physical Environment

KEY FINDINGS:
83% – clinical ethicists or ethics team available
78% – policy/procedure for advance care directives (most were limited in scope to DNR decisions)

RECOMMENDATIONS:
1. Provide access to a clinical ethicist or ethics team to support staff, patients, and families
2. Develop formal practices/policies to ensure autonomy and capacity of patients are observed
KEY FINDINGS:
34% – use SFH resources in planning of physical environment (most continue to rely on building code and AODA guidelines)

RECOMMENDATIONS:
1. Utilize SFH design resources in addition to accessibility guidelines to inform physical environment planning
2. Conduct regular audits of physical environment utilizing SFH resources and clinical personnel and implement incremental environmental improvements
Three SFH Priorities for Action

- **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
FH “Promising Practices” Toolkit

- Literature Review
- Shortlist of Clinical Tools/Resources
  - feasible in multiple hospital settings
  - modest resource/training needs
  - encourages inter-professional care
  - enhances care for patients

34 TOOLS/RESOURCES

Rating by Clinicians/Content Experts Across Ontario
- 39 people participated
- 499 survey responses

19 TOOLS FOR INCLUSION IN TOOLKIT
SFH “Promising Practices” Toolkit

Visit the site at: www.seniorfriendlyhospitals.ca

The Senior Friendly Hospital Toolkit

Teamwork and Inter-Professional Care in a Senior Friendly Hospital

One of the challenges in providing optimal care for frail seniors in hospital is that their overall health and function is related to many interacting factors in addition to their presenting acute illness. These include the ever changing status of chronic ailments, the complex interaction of multiple medications, the effect of psychosocial factors, the availability of family and caregiver support, and the safety and comfort offered by the physical environment. With this clinical complexity, the problems that frail seniors experience in hospital typically require multi-dimensional solutions and the contribution of multiple health disciplines. Teamwork and inter-professional collaboration are essential skills in a Senior Friendly Hospital.

The management of polypharmacy provides an illustration. In order to promote the safe and optimal use of medications, the team physician should review appropriate prescriptions, the pharmacist should check for potentially dangerous drug interactions, the nurse might advise on appropriate administration routines, the physiotherapist might screen for medication induced mobility impairments, the occupational therapist might advise on devices to assist memory and dexterity, and the social worker might engage and educate patients and families to promote medication adherence. All the while, the entire team is able to promptly recognize and communicate change and adverse reactions noted during the course of interactions with the patient. While this is a very simplified example, it illustrates an important point: the skills of the entire inter-professional team and effective communication are important enablers of success in geriatrics best practice.

The Senior Friendly Hospital Framework

The evidence also informs us that a systemic approach to the care of frail seniors, one that considers the influences of the entire care-giving environment, is associated with positive outcomes. Building upon this evidence, the Regional Geriatric Programs of Ontario have developed and endorsed a Senior Friendly Hospital framework to promote an organization-wide approach in service planning and care for seniors. The framework has five components:

1. Organizational Support – There is leadership and support in place to make senior friendly care an organizational priority. Hospital leadership committed to senior friendly care empowers the
DELIURM SCREENING AND DETECTION

The Confusion Assessment Method (CAM)

OVERVIEW:
The Confusion Assessment Method (CAM) was originally developed in 1988-1990 to improve the identification and recognition of delirium. The CAM is consistent with the DSM-IV criteria for delirium. It was designed for both clinical and research applications to provide a standardized method for non-psychiatrically trained health professionals to identify delirium quickly and accurately.

AUTHORS/PRIMARY REFERENCE:

STRUCTURE-OF-THE-TOOL:
The most basic form of the CAM comprises four items, each reflecting a cardinal feature of delirium:
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 either 3 or 4.

BASE OF EVIDENCE/PsYCHOMETRIC PROPERTIES:
- Sensitivity: 74-93% (95% confidence interval)
- Specificity: 87-95% (95% confidence interval)
- Inter-rater reliability: 91.00 (for presence/absence of delirium), 94.80.93 (for all 4 CAM items)

TARGET POPULATION AND SETTING:
- Confused older people in hospital
- Emergency Departments
- Intensive Care Units
- Medical, nursing staff, and other clinicians – training is recommended for optimal use
- An instruction manual is available on-line (see below in “Where to get the CAM”)

NOTES ON USING THE CAM:
- Administration of the CAM takes 5-10 minutes
- It is recommended that the CAM be combined with formal cognitive assessment such as the Mini-Cog test and digit span test
- The CAM has been translated into Chinese, Dutch, Finnish, French, German, Italian, Japanese, Portuguese, Spanish, and Turkish.

WHERE TO GET THE CAM:
An on-line training manual containing the CAM is available at:
http://www.hospitalelderlifeprogram.org/private/cam-disclaimer.php?page=edit (06.00)
- The CAM is a copyrighted tool. It can be reproduced for clinical and research use provided the following acknowledgement is made:
  Confusion Assessment Method: Training Manual and Coding Guide, Copyright © 2003, Hospital Elder Life Program, LLC.

REFERENCES AND ADDITIONAL READING:

Delirium - Screening and Detecting

1. Delirium is common in vulnerable older adults in hospital and is frequently undiagnosed. A high yield of signs should be maintained, particularly when patients display any of a list of risk factors. A sudden change in cognitive, attention, awareness, behavior, or functional status about the day period of delirium and around delirium should be considered in the diagnostic evaluation of delirium and around delirium and should be investigated.

2. The most basic form of the CAM comprises four items, each reflecting a cardinal feature of delirium: (Acute onset, Inattention, Disorganized thinking, Altered level of consciousness) A positive finding for delirium requires the presence of items 1 and 2, and either 3 or 4.

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4. Where to get the CAM:
   An on-line training manual containing the CAM is available at:
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5. The equipment and physical environment related factors:
   - Sensory deprivation or overload
   - Use of restrictive restraints
   - Sleep in intensive care units
   - Length of time in hospital
   - Absence of a clock
   - Absence of usual and hearing aids

6. It is important to educate all healthcare staff on delirium, so that a team effort in recognizing this acute change in mental status can be achieved.
The SFH Indicators Report was approved by the TC LHIN in January 2013
### Delirium Indicators (All Hospital Sectors)

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>Percentage of patients (65 and older) receiving delirium screening using a validated tool upon admission to hospital</th>
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<tr>
<td>OUTCOME</td>
<td>Incidence of delirium in patients (65 and older) acquired over the course of hospital admission</td>
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<tr>
<td>Data Source and/or Tool</td>
<td>Confusion Assessment Method (CAM), CAM-ICU, or Intensive Care Delirium Screening Checklist (ICDSC)</td>
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<tr>
<td>Exclusions</td>
<td>Patients with decreased level of consciousness (unresponsive or requiring vigorous stimulation for a response); patients in palliative care</td>
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<td>Considerations</td>
<td>Minimum frequency of screening to capture incidence – at least daily after the initial baseline screen</td>
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## Functional Decline Indicators (Acute Care Sector)

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<th>PROCESS</th>
<th>Rate of ADL function assessment at admission and discharge</th>
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<tr>
<td>OUTCOME</td>
<td>Rate of no decline in ADL function</td>
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</table>
| Data Source and/or Tool | Barthel Index  
Health Outcomes for Better Information in Care (HOBIC) – ADL Section  
Alpha-FIM Tool® |
| Exclusions | Patients in emergency department who are not admitted to hospital; patients in palliative care; patients admitted for day surgery procedures; patients with a length of stay <48 hours |
Next Step - Implementation

• A sub-working group of the SFH Indicators group has designed an evaluation phase for implementation. Components include:
  - data templates for the indicators
  - written action plans and progress reports
  - staff surveys (pre-, mid-, post-implementation) and interviews
  - monthly support and collaboration teleconferences

• 41 hospitals across 9 LHINs will begin implementation of the delirium and/or functional decline indicators in April 2013

• The evaluation will determine feasibility, data quality, success/challenges, and inform future use of the indicators in quality improvement or hospital accountability structures

• A provincial SFH Collaborative for ongoing knowledge exchange and peer support is proposed
Participating Hospitals

**South West**
- Grey Bruce Health Services
- St Joseph's Health Care (London)
- St Thomas Elgin General Hospital

**Hamilton Niagara Haldimand Brant**
- Brant Community Healthcare System
- Hamilton Health Sciences
- Joseph Brant Memorial Hospital
- Niagara Health System
- Norfolk General Hospital
- St Joseph's Healthcare (Hamilton)

**Toronto Central**
- Baycrest
- Providence Healthcare
- St Michael's
- Toronto East General Hospital
- University Health Network – Toronto Western Hospital
- University Health Network – Toronto Rehab

**Central**
- Markham Stouffville Hospital
- North York General Hospital
- Southlake Regional Health Centre
- Stevenson Memorial Hospital

**Central East**
- Campbellford Memorial Hospital
- Lakeridge Health
- Northumberland Hills Hospital
- Peterborough Regional Health Centre
- Ross Memorial Hospital
- The Scarborough Hospital

**South East**
- Brockville General Hospital
- Quinte Health Care

**Champlain**
- Bruyere Continuing Care
- Deep River District Hospital
- Montfort Hospital
- The Ottawa Hospital

**North East**
- Blind River District Health Centre
- Espanola Hospital & Health Centre
- Health Sciences North
- Kirkland District Hospital
- St Joseph's General Hospital (Elliot Lake)
- Manitoulin Health Centre
- North Bay Regional Health Centre
- Sensenbrenner Hospital
- West Nipissing General Hospital
- West Parry Sound Health Centre

**North West**
- St Joseph's Care Group (Thunder Bay)

**Summary of Implementation:**
- Delirium – 41 patient care units
- Functional Decline – 27 units
Appendix B of the 2013/14 Hospital Quality Improvement Plan Guidance Document, released November 2012, lists SFH indicators as options for inclusion. It refers to:

- The Senior Friendly Hospital Framework
- Indicators to monitor Delirium and Functional Decline

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34 participants with a spread of expertise participated in the Delphi panel and consensus meetings:

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