WAHA 2016-17 Senior Friendly Hospital Improvement Plan - Instructions

Room for growth in providing Senior Friendly care exists for all partners in the healthcare system. To encourage ongoing quality improvement in seniors’ care, Ontario hospitals are required to develop Senior Friendly Hospital (SFH) Improvement Plans. In developing these plans, hospitals are encouraged to consult the following resources:


### Key Considerations

#### Priority Rating
Hospitals are asked to prioritize each change that they have identified in their SFH improvement plan.

#### Objective
The objectives related to functional decline and delirium have been identified as common provincial objectives. These were selected based on the findings from the Senior Friendly Hospital Care Across Ontario provincial report. Hospitals are required to identify improvement initiatives that support these two objectives. Improvement initiatives that are currently being actively implemented can be included.

Hospitals are encouraged to identify additional objectives that fall outside of these two priority areas to address key opportunities for improvement in relation to smooth care transitions for seniors.

#### Change
Hospitals are asked to identify improvement initiatives that support the achievement of an identified objective. Each improvement initiative should be linked to a domain within the SFH framework (see a description of recommended activities within these domains listed below as outlined in the Senior Friendly Hospital Care Across Ontario report).

#### Measure
Hospitals are encouraged to identify outcome measures/process measures/indicators that will allow them to evaluate their achievement against an objective.

#### Barriers/Resource Challenges
If hospitals are having difficulty achieving set targets for identified changes, they are asked to indicate any barriers and/or resource challenges that are impeding the change. They are also asked to identify mitigating factors that explain why it has been difficult to achieve their target.

### Senior Friendly Domains and Recommendations

#### Organizational Support
1) Establish board and/or strategic plan commitments for a Senior Friendly Hospital
2) Designate a senior executive/medical leader in the hospital to lead and be responsible for senior friendly initiatives across the organization
3) Train and empower a clinical geriatrics champion(s) to act as a peer resource and to support practice and policy change across the organization
4) Commit to the training and development of human resources via seniors-focused skill development

#### Processes of Care
5) Implement inter-professional protocols across hospital departments to optimize the physical, cognitive, and psychosocial function of older patients – these processes should include high risk screening, prevention measures, management strategies, and monitoring/evaluation processes
6) Support transitions in care by implementing practices and developing partnerships that promote inter-organizational collaboration with community and post-acute services

#### Emotional and Behavioural Environment
7) Provide all staff, clinical and non-clinical, with seniors sensitivity training to promote a senior friendly culture throughout the hospital’s operations
8) Apply a senior friendly lens to patient-centered care and diversity practices, so that the hospital promotes maximal involvement of older patients and families/caregivers in their care consistent with their personal values (e.g. cultural, linguistic, spiritual)
Ethics in Clinical Care and Research

9) Provide access to a clinical ethicist or ethics consultation service to support staff, patients, and families in challenging ethical situations
10) Develop formal practices and policies to ensure that the autonomy and capacity of older patients are observed

Physical Environment

11) Utilize senior friendly design resources, in addition to accessibility guidelines, to inform physical environment planning, supply chain and procurement activities, and ongoing maintenance
12) Conduct regular reviews of the physical environment and implement improvements informed by senior friendly design principles and by personnel trained on the clinical needs of frail populations

Deadlines

Please have your 2016-17 Senior Friendly Hospital Plans into your respective Outreach Officer by April 1st, 2016. Please see Outreach Officer listing below:

<table>
<thead>
<tr>
<th>Region</th>
<th>Hospital</th>
<th>Outreach Officer</th>
<th>Email</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Priority Rating</td>
<td>Objective</td>
<td>Change</td>
<td>SFH Framework Domain Targeted</td>
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<tr>
<td># 1</td>
<td>Reduce Functional Decline amongst seniors in hospital.</td>
<td>Continue to administer the KATZ assessment tool and develop a better linkage to the patient file for appropriate referrals.</td>
<td>Processes of care</td>
</tr>
</tbody>
</table>
Ministry of Health

Long Term Care
form and/or CGA’s
provided by the
NESGS to update
the status of
inpatients within
the target age
group.

At WGH, the IPD
Charge Nurse
hosts a Nursing
 Rounds session
each Tuesday and
every inpatient’s
care requirements
are discussed
during this
meeting. The
Regional Discharge
Planner, the Social
Worker, the two
Physiotherapists
and the
Occupational
Therapist all
attend this
meeting. The
Charge Nurse and
the health care
team also meet
with the families
of inpatients when
requested to
discuss their care
plans.

In FAH and AH,
Nursing Rounds
sessions are done
every day with the
|   | Reduce Functional Decline amongst seniors in hospital. | Create a standardized referral process (work in collaboration with physicians) to rehabilitative therapy upon admission of patients 65 yrs and above. | Processes of Care | All patients 65 and above in WGH IPD will be referred for a rehabilitative assessment upon admission. | #1 – Number of patients 65 and above who have been assessed vs. number of patients 65 and above admitted to IPD | Establish baseline data for future targets | 75% of our patients 65 and above in WGH IPD have been assessed during April 1, 2015 to March 31, 2016 | Staff turnover impacted progress, leading to delays in the creation of a standardized process | The IPD Charge Nurse identifies inpatients requiring physiotherapy services as part of a nursing report created each day. This information is sent to the Regional Discharge Planner, the Social Worker, the two Physiotherapists and the Occupational Therapist to make sure patient needs are met. At WGH, the IPD Charge Nurse hosts a Nursing Rounds session each Tuesday and every inpatient’s care requirements are discussed during this

Director of Patient Care (DPC) to make each inpatient’s care plan is discussed. The DPC speaks with the Nurse Practitioner to make care plans are updated.
|   | Reduce rates of and/or duration of delirium episodes amongst seniors in hospital. | Conduct screening reviews for the 3 D’s utilizing the Physical Intellectual Emotional Capabilities Environment Social (PIECES) program for patients who are admitted aged 65 and above to the WGH, FAH and AH site. | Processes of Care | Number of inpatients diagnosed with delirium at WGH, FAH, and AH | #1 - Number of inpatients 65 and above seen in IPD’s vs. # of assessments completed from start of project to end of project | Establish baseline data for future targets | 75% of our patients 65 and above in WGH, FAH and AH have been assessed during April 1, 2015 to March 31, 2016 | Staff turnover within clinical positions, impacted this process as many of the staff who received PIECES training in 2014-2015 are no longer with WAHA | WGH’s clinical staff uses a NARC and/or Comprehensive Geriatric Assessments (CGA) provided by the NESGS for those aged 65 and above | FAH and AH clinical staff used a Ministry of Health Long Term Care form and/or CGA’s provided by the NESGS to update the status of inpatients for those aged 65 and above | 2 inpatients were meeting (same as noted in another section above). |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | |
Reduced rates of and/or duration of delirium episodes amongst seniors in hospital.

Provide training supports to WGH clinical and allied health staff for identification of the 3 D's (delirium, dementia and depression)

Organizational support

Number of clinical and allied health staff training on the 3 D’s and how to use the screening tools

#1 - Number of current clinical and allied health staff vs. number of clinical and allied health staff trained to use the screening tools

Establish baseline data for future targets

75% of WGH clinical and allied health staff receive training on the 3 D’s and how to use the screening tools

Training was not offered to clinical or allied health staff

Reduce rates of and/or duration of delirium episodes amongst seniors in hospital.

Conduct follow-up medication reviews as part of the geriatrics specialty clinics in Moosonee, Moose Factory and Fort Albany

Processes of care

Number of follow-up medication reviews conducted in Moosonee, Moose Factory and Fort Albany

#1 – Number of follow-up medication reviews conducted vs. number of patients seen as part of the specialty clinics in each community

Fort Albany – 27 medication reviews completed

Moosonee/Moose Factory – 63 medication reviews completed

75% of follow-up medication reviews completed for each community

No issues noted

WAHA’s clinical team worked with the NESGS and completed medication reviews on 100% the patients initially assessed in 2014-2015 in Fort Albany and in Moosonee/Moose Factory

Some of the patients were seen

2 inpatients were diagnosed with dementia and 2 others were diagnosed with depression at FAH
in the follow-up clinics done in Fort Albany, Moosonee and Moose Factory for 2015-2016 and medication reviews were completed for 100% of patients. For those follow-up patients not seen, the WAHA nurses conducted regular care plan reviews, including medication reviews. WAHA’s physician team also reviews the geriatrician recommendation reports to make sure recommendations are followed.

<p>| To Provide a smooth Transition in care for seniors within the Organization and/or into the Community. | To hold a follow-up geriatrics specialty clinic in Fort Albany in collaboration with the Northeast Specialized Geriatrics Service (NESGS) | Organizational support Processes of care Emotional and behavioural environment | Follow-up clinical reviews conducted for 26 geriatric clinic patients | #1 – Number of follow-up clinical reviews conducted vs. 26 patients seen in Fort Albany clinic | In January 2014, 26 patients were seen in Fort Albany by geriatric specialists | To review and update 26 individualized care plans from the Fort Albany clinic | Limited geriatric services are available within the region—many referrals for more specialized services will need to be conducted externally | 100% performance was achieved and 20 patients from 2014 have updated care plans. 6 other patients from 2014 have been discharged from this initiative list due to status changes. |
| To Provide a smooth | To hold a geriatrics specialty clinic | Organizational support | All patients aged 55 and above will be pre- | #1 – Number of patients receiving a | Establish baseline data for future | 100% of patients aged 55 and above are pre- | Weather issues forced the cancellation of this | The clinic was not completed but |</p>
<table>
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<tr>
<th>Transition in care for seniors within the Organization and/or into the Community.</th>
<th>Peawanuck First Nation in collaboration with NESGS</th>
<th>Processes of care</th>
<th>assessed to determine need for a comprehensive geriatric assessment</th>
<th>pre-assessment in Peawanuck</th>
<th>targets</th>
<th>assessed</th>
<th>clinic</th>
<th>plans for re-scheduling of the clinic are being made</th>
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<tbody>
<tr>
<td>To Provide a smooth Transition in care for seniors within the Organization and/or into the Community.</td>
<td>To hold a follow-up geriatrics specialty clinic in Moosonee/Moose Factory in collaboration with the Northeast Specialized Geriatrics Service (NESGS)</td>
<td>Organizational support</td>
<td>Follow-up clinical reviews conducted for 63 geriatric clinic patients</td>
<td>#1 – Number of follow-up clinical reviews conducted vs. 63 patients seen in Moosonee and Moose Factory clinic</td>
<td>In February 2015, 63 patients were seen in Moosonee and Moose Factory by a geriatric specialist or diabetes NP specialist</td>
<td>To review and update 63 individualized care plans from the Moosonee/Moose Factory clinic</td>
<td>Limited geriatric services are available within the region – many referrals for more specialized services will need to be conducted externally</td>
<td>100% performance was achieved and 51 patients from 2015 have updated care plans. 12 other patients from 2015 have been discharged from this initiative list due to status changes.</td>
</tr>
</tbody>
</table>

SFH Domain Legend

Organizational Support
Processes of Care
Emotional and Behavioural Environment
Ethics in Clinical Care and Research
Physical Environment