Ontario Health

Self-Assessment Tool: Alternate Level of Care (ALC) Leading Practices to Prevent Hospitalization and Extended Stays for Older Adults

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HOW TO USE THIS TOOL

This implementation tool is intended to be used in conjunction with the *Leading Practices to Prevent Hospitalization and Extended Stays for Older Adults (2021)*. *<ADD LINK>*

For each leading practice: Under "Status", click "Select", then click the arrow beside "Select". A drop-down menu appears. Click one of the three drop-down choices to indicate your organization's status in implementing the leading practice:

Met	Your organization(s) or OHT can clearly demonstrate that the leading practice has been implemented and **sustained**. The leading practice occurs 80% of the time.
Partial	Your organization(s) or OHT has taken SOME steps towards implementing the leading practice. The leading practice occurs between 60-80% of the time.
Unmet	Your organization(s) or OHT has taken NO steps towards implementing the leading practice. The leading practice being assessed occurs less than 60% of the time.

NOTE: For acute and post-acute areas, all applicable units must have implemented and sustained the leading practice in order to select the status of "Met".

If some units have not implemented and sustained the leading practice, select "Partial" instead.

For OHT's, all applicable organizations must have implemented and sustained the leading practice in order to select the status of "Met".

If some organizations have not implemented and sustained the leading practice, select "Partial" instead.

Use the "Implementation Notes" section to add details about how your hospital has met the leading practice, plans to meet it, or any identified challenges in meeting the practice. Refer to the *Hospital Alternate Level of Care (ALC) Leading Practices Guide* (2021) for suggested implementation tools.

Designate an implementation team- ideally, an interdisciplinary team (which may include clinical leaders with geriatric expertise, quality improvement staff and individuals focusing on transitions and flow as part of their core portfolios) would take the lead in championing the leading practices by working across the ED and applicable hospital units to review and complete the self-assessment and set priorities moving forward for ongoing implementation, monitoring and assessment.

Develop a manageable plan: Celebrate the successes that your organization has already accomplished, and build on these successes by creating a manageable plan. To do this, decide on a few priorities, including some "quick wins" to start with and make a plan to achieve these goals.

LEGEND

*** -** Leading Practices that demonstrate alignment to Accreditation Canada (AC) Standards. A supplementary document is available that includes a full list of the aligned AC Standards.

sf - Leading Practices that demonstrate alignment to the sfCare Self-Assessment tool. A supplementary document is available that demonstrates specific alignment to the sfCare Self-Assessment tool.

SELF-ASSESSMENT TOOL

A. Priority Leading Practices across the Organization

GOAL: Senior friendly care (sfCare) as the foundation of care

Senior Friendly Care (sfCare) is evidence-based, 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. Senior friendly processes of care include: delirium, mobilization, social engagement, nutrition, pain, polypharmacy, and urinary incontinence. *The sfCare Framework* provides the basis for what sfCare looks like in an organization, including the need for all care providers to have the knowledge and skill required to provide sfCare.

Embedding sfCare as the foundation of care requires an organization-wide approach and the commitment of the senior leaders. sfCare approaches improve the quality of care for older adults, foster desired outcomes and contribute to reduced length of stay (LOS) and ALC.

This goal aligns directly to the Accreditation Canada (AC) Standard "Services are co-designed to meet the needs of an aging population" and is considered High Priority criteria.

Organizational Leadership & Support	Overall Assessment of this Practice		Supporting Information
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
1. A member of the Senior Leadership team (such as a vice president) is designated as accountable for sfCare. **sf**	Select		
2. Commitments to sfCare are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives. **sf**	Select		
3. A sfCare self-assessment is completed to understand the current state of senior friendly care delivery within the organization and opportunities for improvement. **sf**	Select		

4. A set of ALC-related process and outcome measures are collected, monitored and regularly reviewed by senior leaders, managers, physicians and staff.* **sf**	Select		
5. Functional decline and delirium are recognized as preventable harms and risk to the safety of older adults. **sf**	Select		
6. The structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being. **sf**	Select		
7. Clinicians who specialize in geriatric care are available 7 days a week to support a comprehensive assessment and care of older adults. **sf**	Select		
8. A training plan is in place for all staff, physicians, and volunteers so that they are proficient in the provision of sfCare, including: a. Seniors' sensitivity - i.e. communication, general awareness on aging and the special needs of older adults with frailty, and recognizing and addressing ageism; **sf**	Select		
b. delirium prevention and management* **sf**	Select		
c. mobilization* **sf**	Select		

9. Training is provided to hospital staff and physicians to ensure clarity and consistency regarding: a. How early transition planning is incorporated into the admission process and monitored.	Select		
b. When to recommend an ALC designation.	Select		
10. Guiding documents (e.g. polices, standards, procedures, guidelines, care pathways etc.) reflect senior friendly values and principles; promote older adult's health, autonomy, dignity and participation in care; and ensure that an older adult will not be denied access to care or the opportunity to participate in research or quality improvement activities based solely on their age, as applicable. **sf**	Select		
11. Formal partnerships are in place with care delivery partners to support smooth and timely transitions from the ED, acute and post-acute care (e.g. pre-arrangements negotiated through Memoranda of Understanding and/or Purchase of Service Agreements).***** **sf**	Select		
12. Policies and procedures are in place to ensure ongoing reassessment occurs over the course of an older adult's admission. This includes intensive assessment of older adults who are long-stay ALC.	Select		

13. An escalation process is in place which provides clear direction about when and how to engage leadership in discussions around challenging barriers to transition for older adults at risk of an avoidable admission and potential ALC designation. This includes non-punitive audit and feedback as part of an overall performance and quality improvement evaluation.	Select		
Older Adult & Caregiver Experience & Communication	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
14. A process is in place to ensure that the older adult and their designated caregiver / Substitute Decision Maker (SDM) are included as part of the care team.* sf	Select		
15. The care plan, goals, and expected results of care are developed in collaboration with all members of the care team and the older adult and their designated caregiver / SDM, and are flexible and aligned with the older adult's preferences (what matters most). * sf	Select		
16. The older adult and their designated caregiver / SDM are provided with information in their preferred format to let them know what to expect in their care, help them make decisions, and better self-manage their conditions (10,32). This includes being provided with: * sf	Select		

a. Information on mobilization and delirium prevention to support the prevention of functional decline;			
b. The tools to support health literacy and language needs (an advocate, interpreter, etc.) so they can fully participate in their care; and	Select		
c. Information on the role of the hospital, the SDM, co-payment costs, and a plan to participate in transition planning.	Select		
17. A system is in place to measure the experience and outcomes of older adults and designated caregivers / SDMs and make improvements based on the results. **sf**	Select		

B. Priority Leading Practices in the ED

GOAL: Ensure Practices & Structures are in Place to Avoid Unnecessary Admission

The care provided in the ED has the opportunity to 'set the stage' for subsequent care provided throughout the older adult's care trajectory. The older adult population accounts for a large and ever increasing proportion of ED visits. The majority of "at-risk" older adults ultimately designated ALC are admitted through the emergency department.

Early Identification & Assessment	Overall Assessment of this Practice		Supporting Information
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
1. A screening process/tool is used for early identification of "at risk" older adults presenting to the ED, regardless of presenting issue and inclusive of social factors. The risk screen should tie directly into the comprehensive assessment.* **sf**	Select		
2. An interprofessional team who has skills and expertise in the assessment and management of older adults with frailty is available to support assessment and care of the older adult including:* **sf**	Select		
a. Geriatric Emergency Management Nurse (GEM);	Select		
b. Social Worker;	Select		
c. Home and Community Care coordinator;	Select		
d. Physiotherapist, Occupational Therapist, Pharmacist, Behavioural Support clinicians, and other health professionals as needed; and	Select		

e. Consultation with geriatric physician specialists (geriatric medicine, geriatric psychiatry, Care of the Elderly) as indicated.	Select		
3. A comprehensive assessment is initiated, which accounts for physical, cognitive, functional, and psychosocial domains, and includes:* **sf**	Select		
a. A collateral history from a designated caregiver, SDM, or primary care provider.	Select		
b. Identification of baseline functional status e.g. 2 weeks prior to illness onset.	Select		
c. Identification of goals of care, outstanding care needs, and what matters most to the older adult and designated caregiver / SDM (e.g., what are they most concerned about in the short term and long-term?).	Select		
Care Plan Development & Ongoing Reassessment	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practice	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
4. A plan of care is developed by all members of the care team with the older adult and their designated caregiver / SDM and relevant community partners to address care needs with a focus on transition to the pre-admission destination.* **sf**	Select		

5. Frequent re-assessment of an older adult's status is an essential part of the care process so that changes and resulting support needs are identified as early as possible, and the care plan and goals of care are adjusted accordingly. **sf**	Select		
Intervention/sfCare	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
6. A senior friendly approach to care is implemented and includes: a. Processes for screening, prevention, management, and monitoring of functional decline.* **sf**	Select		
b. Processes for screening, prevention, management, and monitoring of delirium.* **sf**	Select		
Proactive Transitions	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
7. Transition protocols are in place that facilitate the timely communication of clinically relevant information to the older adult and their designated caregiver / SDM and primary care providers, including long term care homes. **sf**	Select		

8. Where appropriate, a clinical decision unit/short stay unit has been considered to support the development of a more comprehensive plan for their transition to the next best level of care or place for care. A protocol is developed and in-place (e.g. pre-printed order set).	Select		
9. In partnership with the older adult and their designated caregiver / SDM, the medication reconciliation process is initiated for older adults with a decision to admit, and can be completed on the receiving unit.* sf	Select		
10. Processes are in place to transition individuals directly to the next best level of care to meet their presenting needs e.g. bedded rehabilitative care.* sf	Select		

C. Priority Leading Practices in Facility-based Acute and Post-Acute Care Areas

GOAL: Avoid Hospital-Acquired Harm & Enhance Well-being

Processes are in place to prevent avoidable harm such as delirium and functional decline while treating and providing rehabilitation from acute illness, and to transition older adults to their next best level of care or place for care promptly.

Early Identification & Assessment	Overall Assessment of this Practice		Supporting Information
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
1. Care delivery partners from all sectors who are already involved in the older adult's care are identified, contacted, and documented when the decision to admit is being made and information sharing is facilitated. **sf**	Select		
2. A designated caregiver / SDM or emergency contact is confirmed and documented (including contact details) within 48-hours of admission for all older adults.*	Select		
3. The older adult has a medication review on admission. The review includes information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and	Select		

options are provided for those unable to afford these costs.* **sf**			
4. Prior to ALC designation, a process is in place to ensure that the following occurs in partnership with older adults and their designated caregiver / SDM: **sf** a. Screening for early identification and risk-stratification as soon as possible upon admission (if not already completed in ED or if the older adult is a direct admission from the community). This includes identification and documentation of baseline functional status e.g. 2 weeks prior to admission/onset of illness.	Select		
b. An interprofessional team continues the comprehensive assessment (physical, cognitive, functional, and psychosocial domains), building from and integrating screening and assessment information that has already been collected (e.g. from care delivery partners, collateral history from the designated caregiver / SDM).*	Select		
c. A comprehensive geriatric assessment is completed, when appropriate (e.g. when an increase in care for an extended length of time is anticipated), in	Select		

partnership with the older adult and their designated caregiver / SDM.*			
d. Determination of the older adult's functional goals and restorative potential to inform the plan of care.*	Select		
e. Identification of barriers to discharge (physical, social, financial, etc.).	Select		
f. A referral, if appropriate, to relevant home and community care services or programs.	Select		
Care Plan Development & Ongoing Reassessment	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
5. Care needs are clearly identified and person-centred goals are developed to address these needs (e.g. what is the change between baseline and current state across the physical, cognitive, functional, and psychosocial domains). **sf**	Select		
6. A plan of care is developed with the older adult and their designated caregiver / SDM and relevant community partners to address the identified care needs with a focus on transition to the community.* **sf**	Select		
7. There is a process for establishing the Estimated Discharge Date (EDD). This process must be	Select		

specific to each older adult and not dependent upon blanket EDD assumptions. **sf**			
8. All older adults and their designated caregivers / SDMs are provided with an Estimated Discharge Date (EDD): within 48 hours of admission to acute care and within 4 days of admission to post-acute care. This also includes a conversation around the transition plan. EDD is reassessed frequently and adjusted to reflect changing clinical need and communicated with the older adult and designated caregiver / SDM.* **sf**	Select		
9. All older adults are assessed daily in acute care and post-acute care so that changes and resulting support needs are identified as early as possible. The care plan and EDD are reviewed with the older adult and their designated caregiver / SDM and adjusted accordingly. **sf**	Select		
Intervention/sfCare	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
10. A minimum standard of daily care (7days/week) delivered by an interprofessional team is in place for all older adults (regardless of ALC designation/discharge destination) to help them maintain and restore function while in hospital so that they are not prevented from returning home as a result of hospital-acquired deconditioning. The standard of care includes general hygiene,	Select		

and senior friendly processes of care that address:* **sf**			
a. Mobilization: screening for functional decline; re-assessment of functional status at least weekly; and tailored mobilization interventions specific to their level of mobility and functional goals which supports participation in activities of daily living, physical activity, and self-care.	Select		
b. Delirium: screening and monitoring for delirium; tailored intervention to prevent delirium; and older adults with delirium having a multicomponent interprofessional management plan.	Select		
c. Social engagement	Select		
d. Nutrition	Select		
e. Pain	Select		
f. Polypharmacy	Select		
g. Continence	Select		
Proactive Transitions	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
11. The older adult has a named healthcare professional who is responsible for timely transition planning, coordination, and	Select		

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communication, and the older adult and designated caregiver /SDM will have their contact information in case they have questions. Before the older adult leaves the hospital, this person ensures an effective transfer (early and timely) of transition plans and information related to the older adult's care. **sf**			
12. A transition plan is developed with the older adult and their designated caregiver / SDM and relevant community partners early in the admission to address care needs, care preferences, and barriers to discharge, with a focus on transition to the community first.***** **sf**	Select		
13. An approach is in place to support the older adult, their designated caregiver / SDM, and staff in challenging ethical situations such as when there are differing perspectives around the EDD or transition plan. This could include holding a family meeting, and/or consulting additional resources **sf**	Select		
14. There is scheduled opportunity for the interdisciplinary team to review all older adults identified as "at-risk"(e.g. "at-risk" (ALC) rounds) at least weekly .	Select		
15. "At-risk" (ALC) rounds include the following: a. Chaired and/or attended by a representative at a director/vice-president-level;	Select		

b. Internal stakeholders (i.e., managers, front line staff etc.). The older adult and their designated caregiver / SDM, along with physicians, are also included in team rounds;	Select		
c. Key external agencies are invited to participate as required (i.e., home care coordinator or community support services representatives); and	Select		
d. Discussion includes a review of risks for each older adult (e.g. outstanding care needs and impact on delayed discharge).	Select		
16. An "at-risk" resolution table is developed, where challenging barriers to transition can be discussed and addressed.	Select		
17. The older adult has a final medication review before returning home. This review includes information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs.* **sf**	Select		
18. The older adult is assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed,	Select		

they are arranged before the older adult leaves the hospital and are in place when they return home. **sf**			
19. A written transition plan, developed by and agreed upon in partnership with the older adult and their designated caregiver / SDM, the hospital team, and primary care and home and community care providers is given to the older adult 2 days prior to leaving hospital. Transition plans are shared with the person's primary care and home and community care providers and any relevant specialist providers within 48 hours of discharge. **sf**	Select		
20. Transition plans incorporate referrals and consideration for programs, services or self-care activities to restore/maintain function recognizing the prevalence of functional decline after a hospital stay. **sf**	Select		
21. The healthcare team explains to the older adult what publicly-funded services are available to them and what services they will need to pay for. The older adult's ability to pay for any out-of-pocket health care costs is considered by the healthcare team. Options for those unable to afford the costs are included in transition plans. **sf**	Select		