

## **Optimal care for seniors in health care facilities**

Opening remarks delivered by Dr. Kathy McGilton, Senior Scientist at Toronto Rehab and an expert in the field of geriatrics, for ***Conversations... Exploring health care issues that affect our community***

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### **Subject:**

What does optimal care look like for seniors in health care facilities and the research, educational and practice recommendations to meet the mark?

### **Demographic Reality:**

Proportional to the size of its total population Canada has one of the largest baby boom generations in the world. Approximately 14% of the Canadian population is aged 65 and over and this is expected to double in the next 25 years. Similar to other countries in the late stages of a demographic transition, the numbers of people aged 85 and over are increasing most dramatically (Novak and Campbell, 2009). In light of all that is happening, and is about to happen, there is a growing interest in Canada in matters relating to aging on the part of a wide variety of stakeholders, including researchers, educators, policy makers, practitioners, and service providers, older people themselves, their families and friends (Novak and Campbell, 2009).

According to a recent report, Northumberland community has one of the largest proportions of persons over 65 ranging from 18 to 25% depending on the town you live in.

**I would like to begin my presentation on what the current situation looks like in most health care facilities (like hospitals).**

### ***The current situation:***

There is a persisting mantra in the Canadian health care system – as in many others - that care can be better for older people in clinical settings. However, before one addresses how we improve health services for seniors, one must first be able to assess the current state of practice. There are a number of realities which require attention. In addition to many more older people presenting for health care as a result of population aging, those who do are presenting with multiple co-morbidities and are often frail (Special Senate Committee on Aging: Final Report, 2009). Notably, up to 45% of elderly persons have a delirium as a result of their condition or even their treatment (Milisen et al., 2001).

Delirium is an acute confusional state brought on by any one or a combination of these factors when in hospital: new medications or change in dose, infections, dehydration, pain not controlled, new location. How this presents is that persons say things that are all mixed up, they might not know where they are; they see or hear things that are not

real; are restless and unable to stay still, may try to climb out of bed, become irritable and angry. All of these symptoms can be overwhelming for family members, staff and most notable, the patient. Delirium may take weeks or months to diminish. There is also a looming dementia care problem whereby provision for this condition does not meet demand (Forbes and Neufeld, 2008) which threatens to become Canada's health crisis of the 21<sup>st</sup> century. Dementia refers to a global loss of cognitive and intellectual functioning that gradually interferes with social and occupational performance and the most common form of dementia is Alzheimers/vascular dementia.

While conventional views pertaining to health care for older people often paint a picture of it as being slow paced, predictable, and less demanding than other specialties, these multiple realities ensure that care of older people in Canadian clinical practice is often complex, unpredictable, and unstable (Leppe, 1991).

A significant factor that continues to hinder the development of clinical practice in Canada is wider social attitudes that filter into the sector. Mirroring US culture, a youth oriented society views growing older as something to be denied and avoided at all costs (Special Senate Committee on Aging: Final Report, 2009). One might think that this is irrelevant to health care, but the influence is subtle. For example, in most rehabilitation facilities in Canada, patients with cognitive impairment (i.e. dementia or delirium) are ineligible for admission to rehabilitation (McGilton et al, 2009). This leads to substantial costs to the health care system as many of these patients await placement in acute care beds, become institutionalized, and within a year are immobile (CIHI data; Jiang et al., 2005). In addition, ageist attitudes in health care leads to incorrect assumptions about the capacity of older people to recover, removes them from decision making processes, and their wishes being ignored (Special Senate Committee on Aging: Final Report, 2009). When older patients present themselves in acute care settings, the focus is typically not on the pre-morbid functioning of the patient, nor on the social aspects of well-being, but on the patient's physical symptoms and their behaviors. In the worst cases, family members are visible within Canadian facilities to provide the care the patient requires but is not receiving (Pringle, 2009).

One underlying concern related to the state of clinical care in Canada are deficiencies professional training around diagnosis and treatment of older people and their conditions. Most medical schools in Canada do not require any exposure to geriatrics during their course (Hogan, 2007). Moreover, analyses of nursing curriculum indicate the very limited gerontological content (Baumbusch and Andrusyszyn 2002; Fagerberg et al. 1997; Fagerberg and Gilje 2007; Ma 2007; Rosenfeld et al. 1999). As a result of limited education on care of older people, almost all health care professional training in the field occurs 'on the job' in Canadian acute care facilities (Earthy 1993). Further, these deficiencies in Canadian professional education do not provide hope for addressing the current shortage of geriatric specialists in the country (only 211 geriatricians in 2007 and even fewer geriatric nurse practitioners CIHI, 2007).

**I have presented some information of the current situation in hospitals: The question you may ask is: What should optimal care look like in hospitals?**

In an ideal world, successful Canadian clinical practice for older people would deliver timely access to comprehensive care based on the best evidence (Health Care in Canada Survey, 2008). This care would be optimized through knowledgeable,

compassionate and skillful health care professionals with expertise in geriatrics and gerontology. In all, care would be collaborative, efficient and integrated.