An Elder-Friendly Hospital: Translating a Dream into Reality

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Abstract
The complex health profile of an older adult entering a hospital presents staff and administrators with a new challenge. This paper documents the Vancouver Island Health Authority’s (VIHA) move towards an Elder-Friendly Hospital (EFH). A new approach to hospital care is described, one that takes account not only of an acute healthcare crisis, but also the developmental phenomena associated with aging, with the likelihood of chronic illnesses compounding both diagnosis and treatment. Customized strategies and suggestions for implementation that may be useful to other healthcare agencies are explained.

The complex health profile of an older adult entering a hospital presents staff and administrators with a new challenge. Not only must the care provided respond to an acute healthcare crisis, it must also take cognizance of the developmental phenomena associated with aging and the likelihood that chronic illnesses are present, compounding both diagnosis and treatment. This paper argues that a new approach to hospital care is required, one that takes account of the special features of being old in a system of care focussed on acute illness episodes. At the Vancouver Island Health Authority (VIHA),¹ we have

¹. VIHA provides a full range of healthcare services to a population of approximately 706,000 people, including hospital, community, home, environmental and public health services, in the areas of both education and prevention. VIHA is managed by an executive team and is governed by a nine-member, government-appointed board of directors. VIHA is one of six health authorities in British Columbia, established in December 2001 by the BC Ministry of Health Planning.
An Elder-Friendly Hospital: Translating a Dream into Reality

developed an approach referred to as the Elder-Friendly Hospital (EFH). Following is the rationale for the development of this approach, the customized strategies used to reach the aim of an EFH and suggestions for implementation that may be useful to other healthcare agencies.

**Rationale for an Elder-Friendly Hospital**

National trends in 1997–98 indicated that older adults (those 65 and over) accounted for 35% of the three million discharges from Canadian hospitals, 52% of the 21 million patient days and nearly one-third of all primary diagnostic and surgical procedures performed in hospitals during this time (Canadian Institute of Health Information 2000). Trends in 1998–99 suggested that older adults (> 65 years of age) were three times more likely than those aged 45–64 to be hospitalized (Statistics Canada 2003).

Hospitalization rates in 1998–99 rose substantially with people aged 75 and over; they were 70% more likely than those aged 65–74 to be hospitalized, yet as a cohort they constituted only 12% of the population. In addition, older adults tended to have longer stays in hospital. “In 1998–99, the average hospital visit of seniors lasted 14 days, compared with less than 10 days per visit among all aged groups under 65” (Statistics Canada 2003). Clearly, this population is the primary user of hospital services.

A social-ecological perspective takes the view that people cannot be understood apart from the environmental context in which they behave (Stokols 1992; Moos 1979). Predicting and planning for change, therefore, must include the study of all aspects of the hospital environment (e.g., physical, social, organizational) in association with the characteristics of aged people. Studying one without the other significantly diminishes the likelihood of fully understanding all relevant mediating factors. In light of these ideas, when older adults encounter the hospital, a dynamic interplay is seen between elements of the hospital environment and the world of elders.

The profile of older adults using hospital services reveals a heterogeneous group. Some older adults are relatively healthy while experiencing an episode of acute illness. However, many entering hospital have coexisting multiple chronic health problems (Palmer 1995). This complicated co-morbid pattern, in combination with their advanced age, general health status, functional ability, cognitive status and nutritional state, increases vulnerability for adverse functional outcomes (Inouye and Charpentier 1996; Karp and Koval 1998).

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2. “Elder-friendly” is a term used to denote a hospital that is responsive to the developmental needs of seniors.
The hospital environment is organized to deliver acute episodic care that disadvantages older adults with chronic health problems. The disadvantage stems from systems and processes organized to support the needs of professionals working in that environment rather than the older person’s needs. In addition, the hospital is equipped and resourced to deal almost exclusively with acute illness and medical regimes (e.g., high beds and stretchers, hallways used for storage, dim lighting, high noise levels and poor signage) (Thorne 1993).

Research evidence on older adults’ encounters with hospital systems hint at sentiments of discontent that suggest their experiences have been troublesome. For example, an exploration of the experiences of relatives of stroke patients found that obtaining information was important to families to help them maneuver through the system (van der Smagt-Duijnstee et al. 2000). Timely information is critical to “making sense” of healthcare experiences such as hospitalization, in which older people “explore and seek clarification and understanding about how and why the illness event occurred” (Higgins et al. 1997). In addition to information needs, communication, emotional support, the alleviation of fear and anxiety and pain management have been identified as care concerns and needs of medical patients (Delbanco et al. 1995). Other studies have also cited examples of unfulfilled psychosocial and spiritual needs (Attree 2001; Dady and Rugg 2000; Clark et al. 1997).

The literature is replete with examples of how risky hospital care can be for older people (Dudek 2000; Inouye 2000). Older adults’ baseline vulnerability, combined with precipitating risk factors found in the hospital environment, contribute to adverse outcomes in independent, substantive and cumulative ways (Inouye and Charpentier 1996). This combined effect results in longer stays, increased morbidity and mortality, and increased costs and resource utilization.

What is required is a model of care that acknowledges and responds to the chronic and developmental needs faced by older adults while managing the acute illness episode. It is our contention that customized strategies are key to creating a philosophical shift, one that moves away from the narrow, curative base of traditional biomedical science to emphasize the whole person. Hospitals can achieve this goal by developing customized strategies to produce age-responsive acute care services within existing hospital systems and processes.

Arrangements for hospital care for children serve as a model for a care system that acknowledges both developmental needs and issues related to acute care health services. Hospital care for children is organized around family-centred care principles. Likewise, hospital care for older adults must be founded on gerontological principles. The Elder-Friendly Hospital Initiative includes these principles (see Figure 1). Essentially, this initiative aims to create a cultural shift. Just as hospitals
have learned that children require a different approach to care, so too must care be adjusted for older people and their families.

**The Solution: Customized Strategies**

Customized strategies are invented within the context of a particular facility to “fix the fit” (narrow the gap) between what older adults need and what the hospital environment offers. Such strategies are directed towards fostering positive transactions and diminishing negative consequences that directly affect older people and their experience along the continuum of hospital care from admission to discharge, and beyond into the community.

Customized strategies represent a deliberately constructed, organization-wide network of activity. The seven customized strategies that follow were developed at
The VIHA. They are presented separately for the purposes of this discussion, but are in fact interdependent.

1. High-risk screening

Evidence indicates that high-risk screening (HRS) is an effective mechanism to predict adverse outcomes in older adults (Inouye 2000; Inouye and Charpentier 1996). The goal of HRS is to identify in advance older people whose personal profile (baseline vulnerability), when combined with hospitalization, may lead to functional crises. The intent is to anticipate, predict and prevent remediable problems in a timely manner.

Opportunities for HRS exist at several points along the decision-making continuum that culminates in admission to hospital. For example, HRS can be instituted before admission in the family physician’s office (medical history, physician assessment form) or the surgeon’s office (admission history, pre-operative booking card). Risk indicators can also be applied to assessment processes on entry into the hospital – for example, on admission for pre-planned and booked procedures (medical or surgical) and in emergency departments by hospital staff. The sooner the risk indicators can be applied along the decision-making continuum, the more time there is available to prepare an alternative plan of care to address the older adult’s baseline vulnerability.

Ten indicators to identify an older adult at risk at any point along the continuum are listed in Table 1. These indicators were gleaned from published literature and from the collective experience of clinicians working in medical and surgical areas of the hospital. Column two in Table 1 provides a gerontological perspective for each specific indicator. Although age is recognized as an indicator in combination with other factors, age 75 is used at the VIHA as the marker to initiate the HRS process. The decision to use age 75 as a marker resulted from consultation with geriatric services and a review of the literature that indicated risk generally increased with increased age (Palmer 1995). Further, organizational data indicated that adverse outcomes were most often associated with the 75-and-over age group.

An older adult (now a patient) is identified as “at risk” if he or she is assessed to have more than one indicator present in the profile. When deemed at risk, an Elder Alert (discussed below) is placed in the healthcare record, and the hospital staff who have identified the older adult at risk have the following intervention options:

- geriatric services consultation
- establishing and coordinating a plan of care prior to admission and/or immediately post-operatively
- PT/OT referral and intervention: assessment and intervention through the pre-admission clinic, immediate post-op follow-up
An Elder-Friendly Hospital: Translating a Dream into Reality

Table 1. High-risk gerontological screening indicators. Age 75 is the marker to initiate high-risk screening

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Gerontological Perspective</th>
</tr>
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<tbody>
<tr>
<td>Being seen by a geriatrician</td>
<td>Has a geriatrician seen the person? For what problem? How long ago?</td>
</tr>
<tr>
<td>Mental status</td>
<td>Is there a history of confused episodes at any time (home or hospital)? What were the circumstances? What is the person’s ability to give reliable information, answer questions, focus and maintain attention? Can he/she provide detailed information to questions?</td>
</tr>
<tr>
<td>Alcoholic beverage drinking</td>
<td>Is there a history of drinking alcohol? What is the quantity? Over what period of time?</td>
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<tr>
<td>Taking CNS drugs</td>
<td>Does the person take medication for “nerves,” to induce sleep or for chronic pain? There are a large variety of drugs that may be implicated, in addition to benzodiazepine and neuroleptics.</td>
</tr>
<tr>
<td>Functional mobility</td>
<td>How far can the person can walk? Is he/she housebound, and if so, for what reason? How long does it take him/her to recover from exertion? Does the person use mobility aids? Who will help at home on discharge? (Focus is cardiovascular reserve.)</td>
</tr>
<tr>
<td>Coexisting medical problems</td>
<td>Pay particular attention to evidence of chronic health problems (e.g., diabetes, cardiovascular disease, pulmonary, renal)</td>
</tr>
<tr>
<td>Living arrangements</td>
<td>Does the person live alone? What are his/her self-managed practices? Does he/she use home support? Is he/she a caregiver to someone else at home?</td>
</tr>
<tr>
<td>History of recent fall</td>
<td>Number of falls in the last month? Circumstances around the fall?</td>
</tr>
<tr>
<td>Nutritional status</td>
<td>Loss or gain &gt; than 10 lb in the last year?</td>
</tr>
<tr>
<td>Number of previous hospitalizations</td>
<td>Within the last year, number of visits to ER, GP’s office?</td>
</tr>
</tbody>
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- clinical nurse specialist consultation: establishment of a plan of care prior to admission and immediate post-op follow-up consultation
- community referral
- family and patient education
- management of peri-operative care (e.g., choice of anaesthetic agent, early admission and pre-operative medical assessments).

After an older adult is identified as vulnerable and at risk, an interdisciplinary fan-out is initiated. The interdisciplinary fan-out is a notification of relevant disciplines serving the clinical area in which the older person will be located.

2. Elder Alerts
The Elder Alert is a signal intended to capture the attention of interdisciplinary teams.
It is indicated by the words ELDER ALERT followed by a red asterisk (*). The alert acts in two ways. First, it notifies the professional staff that a particular older patient has been found to be at risk for an adverse outcome. A service-based interdisciplinary fan-out results, and a plan of care is instituted for that particular patient.

For example, Mr. Jones, admitted for a total hip revision, will be assigned a bed in surgical orthopaedics. The pre-admission clinic assesses Mr. Jones to be at risk for post-operative problems (e.g., delirium, constipation, alcohol withdrawal). An Elder Alert would be established for Mr. Jones and an interdisciplinary fan-out initiated. The fan-out constitutes an internal hospital communication process to achieve early assessment and continuity in the plan of care, which is initiated before clinical problems arise and continues as the patient moves through the hospital system. The interdisciplinary fan-out is service-specific and can be used in conjunction with the interventions noted above.

Second, all professionals generally are alerted to consider age-related parameters in selecting appropriate interventions. The following represent five examples of Elder Alerts created in existing hospital systems to prompt professionals to think gerontologically when conducting clinical assessments and selecting appropriate interventions.

**Service-based standardized care plans.** Components of a care plan are adjusted and noted with a red asterisk, and are accompanied by an explanatory note. For example, a note about temperature may be written as follows: “Temperature q4h.* Temperature alone is not a reliable indicator of infection in older adults because of normal physiological age-related changes. Always assess for a change in mental status.”

**Operating room slate and the operative procedural booking card.** The Elder Alert prompts OR staff (e.g., anaesthetist, surgeon, scrub and circulating nurse) to pay special attention:

- to sensory deficits such as decreased hearing
- to speak slowly and clearly
- to increase room temperature
- to select medications judiciously to protect the older adult from iatrogenic consequences.

**Intravenous monographs and pharmacy computer systems.** The Elder Alert provides information about drug dose and administration method and highlights elder-friendly drug choices and alternatives.

**Assessment forms.** Discipline- and service-specific assessment forms (e.g., physician’s admission medical history, nursing assessment forms) provide guidance to focus on gerontologically relevant issues.
Pre-prepared physician orders. The Elder Alert gives suggestions for symptom control options that are most appropriate for older patients (gynaecology, urology, cardiac, general surgery and orthopaedics specialties; see Figure 2).

Figure 2. Orthopaedics pre-order
3. Delirium Watch

Delirium Watch is a surveillance process representing a customized strategy that was developed for a prevalent clinical problem. Delirium in hospitalized older adults accounts for increased mortality, prolonged hospitalization and reduced capacity to perform basic activities of daily living, and leads to higher rates of institutionalization (St. Pierre 1996). Although delirium is said to be a reversible phenomenon, up to 20% of delirious older adults do not return to their pre-morbid
cognitive status (Inouye and Charpentier 1996; Fisher and Flowerdew 1995). Delirium can be predicted with some degree of accuracy. Such knowledge makes it mandatory that an EFH seek to manage this clinical problem.

Delirium Watch combines high-risk screening with the Elder Alert signal to enable professional staff to anticipate, prevent and – should it occur – reverse this problem as soon as possible by implementing appropriate gerontologically based interventions. Components of Delirium Watch are regular assessment checks (three times per day), service-specific targeted interventions, physician-based protocols for contributing antecedent clinical issues (e.g., pain management, constipation, disruptive behaviour) and algorithms for disruptive behaviour management problems.

4. Unit-based interdisciplinary working groups
Interdisciplinary working groups were developed by hospital staff who self-selected on the invitation of their program or service manager. The unit-based interdisciplinary working groups were supported to contribute to quality improvement activities on staff units. Such groups were a way to:

- locate department, unit, program or service gerontological champions at the local service level
- “tool up” champions to empower them to act on improving hospital systems in their locale
- build the capacity of front-line acute care staff through support, education and the celebration of successes.

Three benefits are obtained by using unit-based interdisciplinary working groups. First, group members’ knowledge of unit, service or program area culture allows for a higher degree of specificity in implementation. Implementation of strategies developed and owned by professionals who provide direct care to older hospitalized people increases the likelihood of sustaining quality improvement activities.

The second benefit is “cross-pollination” of gerontological ideas. When unit-based interdisciplinary working group members are relocated to other work assignments within the hospital, they carry the discussion about older adults’ needs with them to their new work areas. This was an important network strategy; ultimately, hospital-wide systems and processes were infiltrated by testimonies from staff members with experience applying the gerontological principles to their acute care practice.

Finally, no one discipline can meet all the needs of older adults in hospital. These needs demand a range of interventions and a repertoire of strategies that go beyond any particular discipline. Interdisciplinary teams provide a broad spectrum of services that manage functional, psychological, social, environmental and spiritual care developmentally adjusted to account for the special features of aging.
5. Clinical education programs
To heighten professional staff awareness of gerontological principles, four specific clinical education strategies were integrated with traditional hospital educational processes (e.g., orientation and in-service education).

Clinical Resource Nurse Gerontological Enrichment Program. This was an eight-week program focussed on gerontological nursing theory that included three components:
• directed seminar sessions twice weekly, facilitated by a clinical nurse specialist
• pre-reading with five self-directed learning modules
• work experience to integrate newly acquired gerontological theory in nurses’ acute care clinical practice specialties.³

Hospital orientation. All newly hired nursing staff attend a one-hour introductory session on topics relevant to the acutely ill hospitalized older adult. The content relates to optimizing hospital care through appropriate assessment. It includes such topics as monitoring medications, preventing deconditioning, preventing delirium, promoting nutrition and facilitating discharge planning.

Gerontological nursing workshops. These regular workshops for nurses are also open to other disciplines. Topics are chosen based on clinical quality improvement reviews that occur in the hospital.

Gerontological education for unit-specific initiatives (e.g., Delirium Watch, Pain in Later Life, Mobility Program). These initiatives represent multidisciplinary activities to develop clinically based programs for specific clinical problems known to be significant for an older person in a particular acute care specialty.

6. Community partnerships and linkages
Community partnerships serve two purposes. First, they provide the wider community (e.g., volunteer, not-for-profit and religious organizations; seniors’ groups, gerontology associations and academic institutions) an opportunity to infiltrate hospital systems, which historically have been closed to them. Second, partnerships permit the hospital to contribute to healthy aging activities by promoting prevention initiatives that in the long term can affect utilization trends (e.g., municipal sidewalk construction for fall and fracture prevention, recreational programs for heart health exercise programs). Two initiatives that served these purposes were developed.

Older Adult Readiness for Hospitalization. This program targets older adults and their families who are preparing for admission to hospital. Based on an empowerment model, the program is run by seniors, and provides a workbook and tips for a

³ Details of this program are scheduled for publication in Journal for Nurses in Staff Development, November/December 2003 issue (volume 19, number 6).
An Elder-Friendly Hospital: Translating a Dream into Reality

73

successful hospital experience.

**Seniors Listening Project.** This program draws on older adults’ lived experiences of hospitalization. Speaking with seniors acknowledges that they are uniquely qualified to determine what works best for a positive hospitalization experience. Key to a listening project is the subsequent use of seniors’ information to influence strategic planning in the hospital.

**Listening projects can be implemented in various ways.** The VIHA initially used community focus groups that were conducted in partnership with the local university. Findings from the project were brought to an advisory committee for service- and program-based response.

7. **Non-patient care services**
All hospitals have support services that include:

- budgeting and finance processes to support the acquisition of new equipment
- dietary and nutritional services for preparation of geriatric-friendly meals
- maintenance departments that are responsible for such functions as the upgrading of hospital buildings and signage
- new construction, facility planning and redesign.

Purchasing elder-friendly equipment promotes independence by facilitating mobility; this, in turn, helps prevent the deconditioning often associated with prolonged bed rest and longer lengths of stay. In addition, lower beds and stretchers, walkers, magnifying glasses, optimal lighting and hearing-aid batteries support functional ability. Hospitals that use a matte floor finish instead of a high-gloss finish can decrease glare. The placement of handrails in corridors at the appropriate level can support balance, aid mobility and contribute to falls prevention. Maintaining clear hallways encourages independence by facilitating self-propulsion in wheelchairs.

In addition to offering elder-friendly diet choices, food services can apply gerontological principles when purchasing replacement cutlery and dishes (e.g., cups with appropriate handles and spoons with larger depth). This strategy supports and fosters abilities in independent functioning, which is achievable within existing operating budgets. Food services departments have an advocacy role to encourage manufacturers of pre-packaged foods to develop packages that are more easily opened.

Hospital foundations and community service groups can aid in the purchase of larger room numbers, calendars and clocks in patient rooms and the modification of bathrooms (e.g., raised toilet seats, lever handles for door). In addition, way finding can be supported with the purchase of symbol signs (kitchen, bathroom, tub room).
Suggestions for Implementation

First, establish both administrative and medical corporate sponsorship. In the VIHA, initial coordination and endorsement of activity were established through an advisory committee representing key stakeholder groups. Second, efforts were made to integrate gerontological principles with information valued by key stakeholders. For example, when information about older adults was presented in hospital, key stakeholder groups focussed on different types of information; each type had to be presented and utilized to make improvements. Clinicians were interested in the efficacy of treatment strategies; physicians and administrators were interested in efficacy of treatment strategies but also length of stay, the cost–benefit ratio and safety. Finally, family and older patients were interested primarily in recovery, functional ability and maintaining independence. The intent was to target information to the major interests of the key stakeholder groups. All groups contributed in creating the EFH.

It was critical to demonstrate a need for change that was recognized by corporate sponsors and clinical practitioners. Meaningful information about such factors as critical incidents, client demands or community initiatives, such as seniors’ advocacy groups, assisted in demonstrating the need for change.

Search for creative people who have innovative new ideas based on their experiences working with older adults, and then convert their ideas to customized strategies. Package and present ideas in ways that enable others to understand the potential and added value to support quality improvement and patient safety.

Finally, build gerontological networks of collaboration to support the development of new ideas, technology and treatments that have cost-neutral impacts on hospital systems, to the extent possible. The existence of a network establishes a critical mass of professionals who are gerontologically responsive and who monitor hospital activities, always alert to elder-friendly opportunities.

Evaluation: The Measure of Success

Evaluation of a philosophical concept is difficult. VIHA has attempted to evaluate progress by targeting the clinical utility of customized strategies. The approaches to date incorporate measures of success that blend qualitative (e.g., patient and staff interviews or focus groups) with quantitative approaches (survey questionnaires, pre- and post-operative patient cognitive scores, length of stay). Indicators such as decreased adverse outcomes (e.g., prevention and early detection of delirium); increased patient, family, staff and physician satisfaction; decreased use of restraints and catheters; decreased numbers of falls; and increased interdisciplinary team autonomy are used to measure the impact of various customized strategies in appropriate clinical programs. Evaluation has been undertaken to study the clinical utility of Delirium Watch and the evaluation of high-risk screening and Elder Alert signals in emergency and orthopaedic services. Preliminary results show that at-risk older
adults are appropriately identified and provided with gerontologically based clinical plans of care. A decrease in the length of stay has been demonstrated in the orthopaedic surgical total hip and knee replacement population (Parke and Foster 2003).

**Conclusion**

We have come to realize that simply trying harder cannot do the job of improving care to older adults in hospital. The systems and processes in hospitals can unintentionally make it easier to do the wrong thing rather than the right. Even the most knowledgeable people can be caught in processes that serve the system instead of the older patient.

Changing hospital systems to become elder friendly requires a blend of customized strategies consistent with gerontological principles. By applying the ideas proposed in this paper, hospitals can achieve meaningful improvements in care for older citizens.

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**Acknowledgement**

The authors wish to thank the staff of the Vancouver Island Health Authority who guided the implementation the strategies noted in this article: Diana Foster, Donna Mears and Linda Birdsall. Special thanks to Jessie Mantle and Dr. Marilyn Bater.

**References**


From Plato in classical times to the modern medicine of today, clients and their caregivers have described more healing in clients and greater satisfaction in caregivers when client-centred care is the focus of both (Daly 1993). The innovative interdisciplinary approach in creating an elder-friendly hospital (EFH) described in Parke and Brand’s paper not only places the elderly client in the centre of care, but calls us to think gerontologically as clinicians and hospital administrators. Perhaps a radical concept to many professionals in acute care, this attitude needs to become embedded as a moral imperative for all healthcare organizations caring for elder persons today. To think gerontologically, as Parke and Brand have noted, calls for new questions to be asked, along with a new approach to hospital care, which can transpire only with a shift in philosophy, and ultimately a shift in healthcare culture. This proactive program addresses the salient issues in the elderly from a number of perspectives – including honouring the voices of the elder clients themselves as well as the broader community of stakeholders external to the organization.

Gladwell (2002) describes the notion of “a tipping point,” that moment of critical mass or threshold; the boiling point, at the centre of which is the possibility of sudden change. Three characteristics are required to drive this change: (1) contagiousness, (2) the fact that little causes have big effects and (3) the fact that change happens not gradually, but in one dramatic moment. In Gladwell’s (2002) view, there is more than one way to tip this change. It is a function of the people who share the knowledge, the product itself and the environment in which the change operates. When such catalysts are introduced to a system, when it is jolted out of equilibrium, it “tips” because something has happened, some change has occurred in one (or two, or three) of these areas. Parke and Brand’s program, I believe, has the potential for this kind of change. Grounded firmly in evidence-based gerontological principles, this “tipping
point” program is initiated proactively at a point prior to admission. At every step along the client’s hospital journey, up to and including discharge, mechanisms are in place to identify, prevent and provide early detection and treatment of those risks that make this population so vulnerable during illness and hospitalization. Ownership by interdisciplinary team members takes place directly at the clinical interface.

I must make several cautionary comments. First of all, why must everything become a “program” rather than an expectation for the embedding of these concepts into all practice areas? Second, programs such as the one outlined by Parke and Brand must be careful to avoid ageist overtones; “aging” is the risk factor as opposed to the “elder at risk.” Third, a strange paradox may arise: by breaking down the client into parts, there is always the risk that the client disappears – the antithesis of the goals of the program. Finally, I would challenge clinicians to utilize an abilities rather than a deficit focus when dealing with elderly persons.

In spite of these concerns, this long-needed program recognizes that the client is a system, living and “becoming” in a world of systems (O’Connor and McDermott 1997). Clinicians have often viewed themselves as outside the client system, more as objective observers. However, the systems perspective views an observer as always inside, always part of, the observed reality. To this end, an EFH capitalizes on this notion, heightens awareness and situates clinical practice from a perspective that is often undervalued or overlooked. For example, the simple understanding that temperature alone is not a reliable indicator of infection in older adults because of normal age-related changes, and the suggestion of monitoring instead for changes in mental status, allows clinicians to pick up the early and often subtle warning signals and prevent more serious complications. The often-preventable problem of delirium is another key issue in this population that demands mandatory knowledge for healthcare providers.

Healthcare providers enter their chosen professions to help people and to make the world a better place, not to “do harm” to the clients they serve. Yet, as this paper demonstrates, inadvertently, we may miss vital cues from our clients’ physical conditions or from the environment in which we care for them. This lack of valuable information might be the “tipping point” for not only a bad hospital experience, but also potentially serious health and cost outcomes. By providing an EFH approach to care, everyone benefits – clients, families, care providers, healthcare organizations and the entire healthcare system. Whether we work in acute care, long-term care or the community, let us rise to the challenge of thinking gerontologically.

References