1976
DEC.

# A BRIEF REGARDING

## EDMONTON HEALTH SERVICES TO SENIORS

**Discharge Planning, Early Detection and Prevention of Illness**

The following brief was prepared by the Edmonton Social Planning Council, on request by Co-ordinators of Volunteer Services to Seniors.

December 1976

A BRIEF REGARDING

# EDMONTON HEALTH SERVICES TO SENIORS

Discharge Planning, Early Detection and Prevention of Illness

## INTRODUCTION

This brief was written in response to a community workshop sponsored by Co-ordinators of Volunteer Services to Seniors, on behalf of senior citizens and workers in health and social services to seniors. Specifically, Volunteer Co-ordinators for Senior Citizens are concerned with problems senior citizens encounter upon hospitalization and discharged back into the community, and problems related to the assumed co-ordination between institutional services and community services.

Health care for the elderly is a broad topic area, which includes preventive health services, home treatment services and institutional health care. This brief will concentrate on specific services within two general areas of concern which have been expressed by workshop participants:

I. Hospital Discharge Planning

II. Early Detection and Prevention of Illness.

These sections include recommendations, followed by a summary of recommendations. Included in Appendix I are documented examples of problems happening to seniors due to inadequate admission and/or discharge procedures. Appendix II includes a list of Volunteer Co-ordinators for Seniors.

This brief is primarily directed to those departments which assume responsibility for planning and co-ordinating services to seniors. In particular, this includes:

(a) Alberta Department of Social Services and Community Health, Senior Citizens Division;

(b) Social Planning Section, Edmonton Social Services;

(c) Society for the Retired and Semi-Retired;

(d) Alberta Council on Aging.

## I. HOSPITAL DISCHARGE PLANNING

Considerable concern has been expressed regarding the need for some responsible person to be notified of a patient's release from hospital, and where necessary, community based health services be available to seniors upon discharge. Specifically, discharge planning concerns in this brief focus on:

(A) ADMISSION INFORMATION
(B) NOTIFICATION SYSTEM
(C) HOLDING UNITS
(D) MEDICAL AID INFORMATION.

### (A) ADMISSION INFORMATION

The notion that planning of adequate discharge arrangements is facilitated by relevant and sufficient admission information has been frequently expressed. Currently, hospital admission information in Edmonton concentrates on items included in Hospital Assessment and Admission Form 290. It is suggested here that additional admission information be sought related to discharge needs. This includes information determining whether or not the elderly person lives alone, the availability of relatives or friends to transport if necessary and provide home supervision to elderly people who live alone and may require aid. Information of this nature would help indicate the necessity for discharge follow-up. Discharge planning begins upon admission. Relevant admission information is a prerequisite to discharge planning, and prevention of hardships and suffering related to lack of transportation and home supervision for seniors who may require aid.

### (B) NOTIFICATION SYSTEM (REFERRALS)

Presently, referrals to hospital social service departments are at the discretion of the patient's hospital doctor. The patient's doctor has to give his permission before a patient can be seen by a hospital social service worker. The social worker then refers him, if necessary, to community care workers (i.e., Edmonton Home Care Program, Homemakers, Friendly Visiting, Victorian Order of Nurses, Meals on Wheels,

volunteers). In practice, it was reported that referrals to social service departments are few. One problem expressed in relation to this is the difficulty for a physician to spend an adequate amount of time with the elderly patient to know his personal circumstances. Similarly, physicians working in emergency departments often have so many patients to attend to that they have little time to consider the patient's home circumstances. In addition, the referral process may take some time, involving communication between the patient's physician at his discretion to social services, who must then become familiar with the patient and his circumstances, and if necessary make referrals to community based home support services. Meanwhile, a sick elderly person who lives alone may be without help or support.

In order to help alleviate this problem, it has been strongly suggested that a more direct notification system be established, based on admission information. Should admission information indicate that discharge planning is required, this information may be passed on immediately to the hospital social service department, which then assumes responsibility for organizing and coordinating community transportation, health, and home support services and preventing unnecessary overlap of services to discharged and elderly patients. This recommended change in hospital referral policy was frequently repeated as badly needed, and would be significant in preventing unnecessary hardship and suffering of discharged patients due to lack of discharge planning.

### (C) TEMPORARY EMERGENCY CARE: HOLDING UNITS

Another concern which has been expressed is the idea that an elderly patient may be discharged from hospital prior to arrangement of necessary community support services for that individual. The elderly person in this instance may be without family and friends to provide support, and may fear being alone. A senior can be discharged late Friday afternoon or on weekends, for example, when hospital referral services and community services have closed for the weekend. In order to control this problem, it was suggested that small hospital

holding units be established for the purpose of taking in discharged patients, where necessary for a weekend, until services can be contacted and home support arranged.

### (D) MEDICAL AID INFORMATION CARD

Most elderly people (78.7%) do have family doctors according to the Snider Report[1]. The remaining percentage, however, do not have personal physicians. In addition, in the event that the elderly person should require medical help, his personal doctor may not be immediately available. In view of this, it has been suggested that the elderly person, upon discharge, receive a card indicating his family doctor and phone number and other sources of available medical aid (i.e., nearby clinics, emergency departments). It is felt that this information would be helpful in ensuring that the senior citizen requiring medical attention receives it as soon as possible.

---

(1) E. L. Snider, Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta: A Pilot Project, Medical Services Research Foundation of Alberta, Edmonton, pg. 48.

## II. EARLY DETECTION AND PREVENTION

Health care in Canada tends to be institutionally orientated. In view of rising costs of institutional operation, it seems reasonable that health education measures, early detection and home care would be significant in reducing the rate of hospitalization, and enabling seniors to remain independent as long as possible. This is especially important in view of the increasing numbers of elderly citizens in our population. The absolute number of elderly persons, for instance, has increased by over 20% in the five year period 1966 to 1971 in Edmonton[(1)]. A recent study of community services for the aged in several European countries has indicated that non-institutionalized health care for seniors was the most important means of controlling the need for institutional facilities[(2)]. Specifically, expressed needs related to detection and disease prevention included:

(A) NEIGHBOURHOOD CLINICS
(B) TRAVELLING CLINICS
(C) DAY HOSPITAL CARE.

### (A) NEIGHBOURHOOD CLINICS

The idea of neighbourhood clinics, staffed by a socio-medical team, is directed towards urban areas containing a high density of senior citizens, such as the Boyle Street/McCauley area in Edmonton. Community oriented health clinics are designed to make more accessible medical examination and health education (i.e., nutrition, exercise) to medically and socially isolated seniors. Combined with an outreach program, clinics may be used to inform elderly citizens of neighbourhood medical services and other community resources available to them, and encourage these people to utilize services. This is designed to help prevent health disorders, and detect disorders before they become serious and require patient's hospitalization. The clinic staff may take an active role in connecting people in need to a range of medical

---

(1) Edmonton Services to the Elderly, (1974, A Report Prepared by Edmonton Social Services, Social Planning Section, and the Society for the Retired and Semi-Retired), p. 4.

(2) N. Markus, "Home Care for the Aged", CW1, Canadian Welfare, (January - February, 1974, vol. 50, no. 2), pgs. 17-19.

and social services, and where appropriate, provide follow-up. For seniors, handicapped by failing health or limited mobility, the availability of nearby medical services means reassurance about the possibility of a crisis arising with which they are unable to cope. A recent report on a community outreach clinic indicates that this was the case in Winnipeg where isolated elderly husbands or wives, caring for the sick spouse, were somewhat less fearful of disaster due to the nearness of a neighbourhood clinic[1].

Currently in Edmonton, preventive health services (i.e., Home Treatment Services) are limited in the numbers of people they serve, in relation to the estimated need[2].

## (B) TRAVELLING HEALTH TEAM

As an element of the neighbourhood clinic, the need has been expressed for a travelling health team to provide home medical diagnosis, aid, referral, to those elderly citizens with limited mobility. This should include regular follow-up visits.

## (C) DAY HOSPITAL CARE

Day hospital care is designed to prevent institutionalization and to shorten the length of stay in active treatment hospitals. It has been recommended that this service be expanded for those elderly people whose illnesses are not serious enough for them to be admitted to active treatment hospitals, but who live alone and need medical supervision. Day hospital provides medical, nursing, physiotherapy, occupational therapy, speech therapy and dietary counselling. Current facilities in Edmonton, in Dr. Angus McGugan Nursing Home, can only handle up to 25 patients per day[3].

---

(1) Mark Greene, M.D., et al, "Community Outreach", CW5, (Canadian Welfare, September, 1975, Vol. 51, no. 5), pgs. 10-12.

(2) Edmonton Services to the Elderly, 1974, p. 49.

(3) Edmonton Services to the Elderly, 1974, p. 59.

## SUMMARY OF RECOMMENDATIONS

(a) Additional hospital admission information be sought related to discharge needs of elderly patients.

(b) Hospital policy which makes referrals to hospital social service departments at the command of the patient's doctor be changed in favor of a more direct notification system based on admission information.

(c) Hospital holding units be established for the purpose of supervising, where necessary, discharged patients until services can be contacted and home support arranged.

(d) Elderly patients, upon hospital discharge, receive a card indicating his family doctor and other sources of medical aid information.

(e) Neighbourhood clinics which combine easy access and high quality medical care and health counselling be established. This clinic may be the base for a community outreach program designed to locate seniors in need of services and inform the population about services available.

(f) Travelling health teams provide home medical diagnosis, aid, referral and health counselling to those elderly people with limited mobility.

(g) Expanded day hospital services be established to prevent institutionalization and shorten the length of stay in active treatment hospitals.

## REFERENCES

1. Edmonton Services to the Elderly, 1974, A Report Prepared by Edmonton Social Services, Social Planning Section, and The Society for the Retired and Semi-Retired.

2. Mark Greene, et al, "Community Outreach, A Socio-Medical Team", CW5, Canadian Welfare, September, 1975, Vol. 51, no. 5.

3. Markus, N., Home Care for the Aged, CW1, Canadian Welfare, January - February, 1974, Vol. 50, No. 2.

4. Snider, E. L., Medical Problems and the Use of Medical Services Among Senior Citizens in Alberta: A Pilot Project, Medical Services Research Foundation of Alberta, Edmonton.

## APPENDIX I

## DOCUMENTED CASES

The following cases have been submitted by a social service worker, City of Edmonton, and a public health nurse.

Signed originals are on file at the Edmonton Social Planning Council.

## SOCIAL SERVICE WORKER

1. An 81-year-old lady living alone in her own home was sent to the University of Alberta Hospital after drinking a cup of lye by mistake. She was detained at hospital for several weeks, discharged on the day before Good Friday and no one was told that she was at home. The tube was still in her throat and she was filling it and feeding herself until Tuesday morning when a neighbour phoned the Duggan office re her condition.

2. A man of 73 was sent home from Royal Alexandra Hospital with a cast on his foot and was not told of the importance of having the cast changed if his foot became swollen. When I was called in, his toes were purple and the skin bulged over the edge of the cast. He was taken to Emergency at the Royal Alexandra and I asked to be notified when he was sent home. He was discharged and sent home that same day and no one was informed. Again, I was called in by a neighbour who was worried about his condition.

3. A 56-year-old alcoholic was taken by me to the General Hospital Emergency Department in a state of extreme dehydration and malnutrition. He was very vague and could keep nothing in his stomach. I was told there was nothing wrong with him and he could not be admitted. When I insisted on hospitalization, he was sent to the Col. Mewburn Pavilion and he left there on his own and has not been seen since. I was called by the social worker at the Mewburn asking if _I_ knew where he was.

## PUBLIC HEALTH NURSE

A man who was ill and confused was taken to the University Hospital, by a Public Health Nurse, on 17 Feb. '76. This man lived alone, was separated from his wife and family and they wanted nothing to do with him. It was the understanding that Duggan Social Service Dept. or Local Board of Health would be notified upon his discharge.

It was not until early Apr '76 that I was contacted by this man's enstranged wife, wanting to know where he was. I made many phone contacts of his friends, drinking establishments and DUA' - to find this man had not picked up a check since Jan '76. Finally, on 25 April '76, I found out that this chap was alive, and well and had been in a Lodge out of town since 26 Feb '76.

# APPENDIX II

## VOLUNTEER CO-ORDINATORS FOR SENIORS

| | |
|---|---|
| Alice Henbest | Operation Friendship<br>Edmonton |
| Wanda Cree | Society for the Retired and Semi-<br>Retired, Edmonton |
| Dorothy Jacques | City of Edmonton, Social Services |
| Rene Lavid | St. Albert, Preventive Social Services |
| Marie Coventry | West End Seniors |
| Dorothy Gulliver | City of Edmonton, Social Services |
| George Miller | Preventive Social Services<br>City of Edmonton |
| Heather Sparrow | University of Alberta Hospital<br>Social Service Department |
| Hazel Sutherland | Volunteer Action Centre<br>Edmonton |
| Kevin McKinley | City of Edmonton<br>Preventive Social Services |
| Laura Taylor | City of Edmonton, Social Services |