A CASE FOR THE NEED FOR STANDARDS FOR OLDER ADULT RECREATION PROGRAMS:

A LITERATURE REVIEW

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Acknowledgements:

This report was commissioned by Parks and Recreation Ontario. It was completed as part of the first phase of a three-year project, funded by the Ontario Trillium Foundation, to establish a quality assurance framework for older adult recreation programs.

The report was conducted with the support of the National Institute on Ageing (NIA). The National Institute on Ageing (NIA) was established at Ryerson to contemplate both the financial and health aspects of aging. There is no other academic institute in Canada with this dual focus, which differentiates the NIA from other aging-focused institutes and offers a unique opportunity to innovate in the aging space. This Institute is focused on supporting and funding practitioner-oriented, actionable research; education; policy development and innovation related to aging, as well as forging partnerships with other organizations and institutions to advance knowledge and inform policy.

Parks and Recreation Ontario (PRO) is a non-profit association that advances the health, social and environmental benefits of quality recreation and parks through evidence-based practices, resources and collaborative partnerships. PRO supports the recreation sector by providing research and resources that will enhance program delivery and improve outcomes for communities.

HIGH FIVE is Canada's quality standard for children's programs, established by Parks and Recreation Ontario. HIGH FIVE provides organizations with a quality assurance framework, program design guidelines and training for program leaders founded on the Principles of healthy child development. This current project to develop a quality assurance standard for older adult recreation will build on the current HIGH FIVE Standard, which has already been adopted by more than 400 municipalities and organizations in Canada and reaches more than 1 million children annually.

A Case for the need for Standards for Older Adult Recreation Programs

An Exploratory Report

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"You can't help getting older, but you don't have to get old."
George Burns

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Executive Summary

For the first time in Canadian history, people over the age of 65 outnumber those under the age of 15.[i] Governments, organizations and individuals have been working collaboratively to assess the impact of a rapidly ageing population. Undoubtedly, the demographic shift is having significant implications for those who provide services to people in Canada. Building age-friendly communities and implementing innovative approaches to health care services are some of the initiatives governments and other stakeholders are undertaking to ensure that older adults in Canada remain active and engaged in their communities.

In response to the demographic shift in Canada and feedback from recreation providers, Parks and Recreation Ontario is developing a quality framework for older adult programs, based on the HIGH FIVE® Quality Assurance Standard for children's programs[ii]. The first phase of this development included an environmental scan and literature review. This literature review was completed in partnership with the National Institute on Ageing at Ryerson University.

The aims of this review were to:

- Discover if other quality frameworks for older adult programs exist and show the alignment of the HIGH FIVE Standard with existing frameworks for healthy ageing
- Articulate the importance and benefits of a comprehensive quality framework for older adult programs to support for healthy, active ageing
- Assess if the HIGH FIVE principles of healthy development are applicable to older adults
- Make recommendations for any further research.

The review did not find any comparable, recreation-based standard for older adults. Research clearly shows that a framework or quality standard for older adult recreation aligns with and supports the implementation of broader initiatives focused on healthy ageing. The recreation sector is uniquely aligned with WHO's *Global Strategy for Action Plan*, the CIHR-commissioned *National Seniors Strategy* and the *Framework for Recreation in Canada* to promote healthy ageing and active lives, and thereby, serve to buffer the social and economic impact of an ageing population. This alignment provides a clear direction to support the enhancement of HIGH FIVE to meet the needs of an older adult population.

The HIGH FIVE principles are the key elements that support organizations to deliver high quality programs. They are:

1. A Caring Adult
2. Friends
3. Play
4. Mastery
5. Participation

This report clearly shows that the HIGH FIVE principles are aligned with and support the evidence from extant academic literature on the importance of sport and recreation programs for healthy, active aging and quality of life. It also shows that the HIGH FIVE principles and quality standard framework are well-positioned to serve as benchmarks for quality for those programs and that the HIGH FIVE principles are further supported by their alignment with the WHO-initiated Global Age-Friendly Cities Project and the eight key characteristics of age-friendly communities. Furthermore, HIGH FIVE principles offer a framework for superior standards compared to other extant standards used within Canada, none of which address all five principles.

From an individual and societal perspective, the importance of such standards is underscored by the unprecedented growth projections in older adult population, the associated increase in demand for recreation programs and services, the significance of the individual and population health benefits associated with recreation programs, and the role of quality of service on participation.

So, with a clear mandate from recreation providers, strong evidence that the HIGH FIVE standard and its principles will enhance the lives of older adults, further validation, development and consultation will result in a quality framework for older adult recreation that it is evidence-based, responsive and leverages existing resources. Such a framework will ensure that older adults have access to quality programs that enable them to live healthy, active lives in their community.

[i] Statistics Canada. (2015). Annual Demographics Estimates, Canada, Provinces and Territories. *91-215-X.*

[ii] The HIGH FIVE Standard is Canada's only comprehensive standard for children's recreation programs. HIGH FIVE is founded on five principles of healthy development which inform the training, policies and evaluation tools that are part of the overall standard.

Introduction

The world population is ageing at an unprecedented rate. By the year 2050, 2.1 billion of the world's population will be over the age of 60, a significant rise from 901 million in the year 2015. A similar trend in demographic shift is also observed at a national level. In the year 2015, for the first time in Canadian history, the population of individuals over the age of 65 exceeded the population under 15 years of age (Sinha, et al., 2016). By the year 2025, 27.9% of Canadians are expected to be above the age of 60 (World Health Organization, 2002).

The full extent of the consequence of an aging population is unknown. However, a significant change in absolute and relative size of older adult population is likely to be associated with an increase in prevalence of disease and disability. A wealth of evidence indicates that older adults exhibit "relatively higher prevalence of chronic conditions such as obesity, mental health and neurological conditions, cognitive and mobility issues as well as injuries (Annear, Cushman, & Gidlow, 2009). In 2012, over 85% of older adults above the age of 65 years reported having one or more chronic conditions. Approximately a quarter of those reported having three or more chronic conditions and used 40% of healthcare services. The implications of this demographic shift on the capacity of the public health sector as well as healthcare costs to individuals and societies is great (Kerr, Rosenberg, & Frank, 2012; Annear, Cushman, & Gidlow, 2009).

In anticipation of the implications of this demographic shift on public health and the existing public health infrastructures, the World Health Organization proposed a Global Strategy and Action Plan (GSAP) in the year 2014 (World Health Organization, 2015). With the intended outcome of postponing infirmity among older adults and stretching the healthy years well into old age, the GSAP aims to secure the commitment to action of member countries to address five priority areas (see Table 1) between the years 2016-2020 in preparation for a Decade of Healthy Ageing between the years 2020-2030 (World Health Organization, 2015).

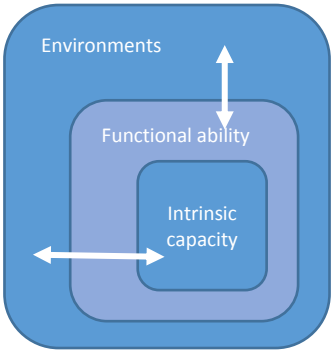
Table 1. WHO Strategies

- Action on Healthy Ageing
- Age-friendly environments
- Health systems aligned to the needs of older adults
- Sustainable and equitable systems for providing long-term care
- Measure, monitor and research

The WHO defines healthy ageing as "the process of developing and maintaining the functional ability that enables well-being in older age." The concept of healthy ageing does not focus on clinical healthcare. Rather, it is primarily based on social determinants of health and focuses on building synergistic interaction between an individual's intrinsic capacity, including health status, and the individual's environment by promoting capacity-enhancing behaviours and removing barriers to participation.

- **Intrinsic capacity**: an individual's total reserve of physical and mental capacities at any given time.
- **Environments**: Physical and social environments that serve as resources or barriers to the function of a person with a given level of capacity.
- **Functional ability**: the health related attributes that enable people to be and to do what they have reason to value.

Reference: (World Health Organization, 2015)



In Canada, the development of the National Seniors' Strategy was commissioned by the Canadian Institutes of Health Research (CIHR) in an effort to bring the need to support the growing number of older adults in Canada to the forefront of the Federal government's agenda. While aligned with WHO's GSAP, the document addresses the unique challenges and opportunities of the Canadian ageing population. The National Seniors' Strategy is founded on five fundamental principles, i.e., access, equity, choice, value, quality, and identifies four pillars that support successful ageing in Canada (see Table 2).

Table 2. The Pillars and Policy Briefs of the National Seniors Strategy

- ***Independent, productive and engaged citizens***
  - ***Making addressing ageism, elder abuse and social isolation a national priority***
  - Ensuring older Canadians do not live in poverty by improving their income security
  - Ensuring older Canadians have access to affordable housing and transportation
  - Enabling the creation of age-friendly physical environments and spaces
- ***Healthy and Active lives***
  - ***Ensuring Canadians are supported to engage in wellness and prevention activities that enable Healthy Ageing***
  - Improving access to medically necessary and appropriate medications
  - Ensuring older Canadians and their caregivers are enabled to participate in informed health decision-making & advance care planning
- Care closer to home
  - Ensuring older Canadians have access to appropriate, high quality home and community care, long-term care, palliative and end-of-life services
  - Ensuring older Canadians have access to care providers that are trained to specifically provide the care they need
  - Developing standardized metrics and accountability standards to enable a National Seniors Strategy
- Support for caregivers
  - Ensuring older Canadians are supported in the workplace
  - Ensuring caregivers are not unnecessarily financially penalized for taking caregiving roles

Source: (Sinha, et al., 2016)

A Role for Sports & Recreation

The Canadian Parks and Recreation Association (CPRA) defines recreation as "the experience that results from freely chosen participation in physical, social, intellectual, creative and spiritual pursuits that enhance individual and community wellbeing" (Canadian Parks and Recreation Association, 2015). People seek recreation for various reasons including "fun, enjoyment, fitness and health, social interaction, creative expression, a desire to connect with nature, relaxation, and to enhance their quality of life." (Canadian Parks and Recreation Association, 2015). These outcomes of recreation overlap with the desired outcomes of the National Seniors Strategy. In particular, recreation can play a role in addressing components of both the 1st and 2nd pillars of the National Seniors Strategy.

Addressing Loneliness and Social Isolation

The first of four pillars of the National Seniors Strategy identifies addressing social isolation as a target of national priority towards supporting older adults in remaining independent, productive and engaged (Sinha, et al., 2016).

Societies are dynamic; they change with time. By and large, today's society no longer conforms to traditional family models wherein parents could expect to live with their children in their old age. In 2011, 92% of Canadian older adults lived in private households wherein 35% of the women and 17% of the men lived alone (Public Health Agency of Canada, 2014). The remainder 8% lived in retirement communities and other facilities/institutions (Public Health Agency of Canada, 2014). Furthermore, with the progression of age, an older adult's social network tends to shrink due to life events such as retirement, relocation and death (Masini & Barrett, 2008). Meaningful relationships are lost and forming new ones becomes a challenge. It is also notable that while living alone does not imply isolation, living among others does not assure feelings of connectedness (Lyons & Dionigi, 2007; Public Health Agency of Canada, 2014). For example, it has been reported that retirement communities often lack the strong sense of connectedness associated with leisure participation (Lyons & Dionigi, 2007). Many older adults are, therefore, at risk of loneliness and isolation (Lyons & Dionigi, 2007).

Loneliness is a subjective feeling of emotional isolation and lack of friendship whereas social isolation represents the lack of social interactions and social network. (Cattan, White, Bond, & Learmouth, 2005). Loneliness and isolation among older adults not only have direct moderating effects on social wellbeing but also indirect moderating effects on physical health. Studies have shown that isolation and lack of social support have health consequences including 'higher risk for decreased immunity, higher blood pressure, arteriosclerosis, and early death'. (Masini & Barrett, 2008).

Participation in leisure activities with social attributes presents an opportunity to alleviate loneliness and isolation and to promote psychological wellbeing among older adults by

buffering stressful life events (Coleman & Iso-Ahola, 1993). Leisure researchers argue that a key role of leisure activities is the creation and nurturing of stable communities based on strong and ongoing relationships (Lyons & Dionigi, 2007). It is recognized that 'parks and recreation movement in countries such as the U.S. have long championed leisure-related services as being central in creating strong and stable communities' (Lyons & Dionigi, 2007). Such relationships and sense of community are believed to significantly affect the quality of life of those in the community.

Promoting Active Living

The second pillar of the National Seniors Strategy emphasises healthy and active lives and recommends the development of policy to promote the engagement of older adults in wellness and prevention activities including regular physical exercise (Sinha, et al., 2016).

Empirical evidence show that many health problems of higher prevalence in old age are associated with progressively sedentary lifestyle and are, therefore, preventable (World Health Organization, 1998; Annear, Cushman, & Gidlow, 2009). Functional decline associated with physical inactivity has been shown to be equivalent to that associated with chronic disease (Rikli & Jones, 1997). Up to 50% of age-related health and physical decline that leads to frailty may have been prevented through timely adaptation to and practice of physical activity (Rikli & Jones, 1997). In spite of the mounting evidence for the health benefits of remaining physically active, the majority of older adults (57% in 2005) are reported to live sedentary lives (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012; Statistics Canada, 2013).

Physical activity can take place in many contexts including transportation, work or household duties as well as leisure time activities. Leisure time physical exercise, i.e., physical activity that takes place as part of exercise, recreation, or sport is of particular relevance to the older adult population as they are relatively less likely to have externally imposed restraints on time and responsibilities (Annear, Cushman, & Gidlow, 2009).

Physical inactivity has both direct and indirect effects on physical impairment and consequent functional deterioration via muscular atrophy and physiological decline, respectively (Rikli & Jones, 1997). Direct benefits of leisure time physical activities include improvements in physical strength, balance and coordination (See Table 3). Many studies show that physical activity interventions reduce risk of falls and hip fractures among older adults (Sherrington, Lord, & Finch, 2004 ;Gregg, Pariera, & Caspersen, 2015; Annear, Cushman, & Gidlow, 2009). In Canada, between 20-30% of older adults experience one or more falls in any given year (Sinha, et al., 2016). The significance of this issue is underscored by the reported annual healthcare cost across Canada related to the injuries from falls is estimated of $2.2 billion dollars and the Government of Ontario effort to mitigate this concern by offering two thousand free exercise and falls prevention classes (Sinha, et al., 2016). In addition to the systemic strain associated with falls, the impact of the burden of fear of falls on the quality of life of older adults, i.e., limitations to functional ability, including loss of physical independence and its implications on social isolation and, overall, aging-in-place, is a growing concern (Rikli & Jones, 1997).

Table 3: Functional performance framework

Physical parameters		**Functions**		**Activity goals**
• Muscle strength/endurance • Aerobic endurance • Flexibility • Motor ability (balance, coordination, speed/agility, power)		• Walking • Stair climbing • Standing up from chair • Lifting/reaching • Bending/kneeling • Jogging/running		• Personal care • Shopping/errands • Housework • Gardening • Sports • Traveling
Physical impairment	→	Functional limitation	→	Physical disability/dependence

Source: (Rikli & Jones, 1997)

In addition to the role of physical activity on functional performance, several longitudinal epidemiological studies have provided empirical evidence for the association of physical activity with declines in morbidity and mortality (Kerr, Rosenberg, & Frank, 2012). Leisure time physical activities have been associated with several benefits to physical health including reduced risk of onset of age-related heath conditions such as ‘cardiovascular disease, hypertension, elevated

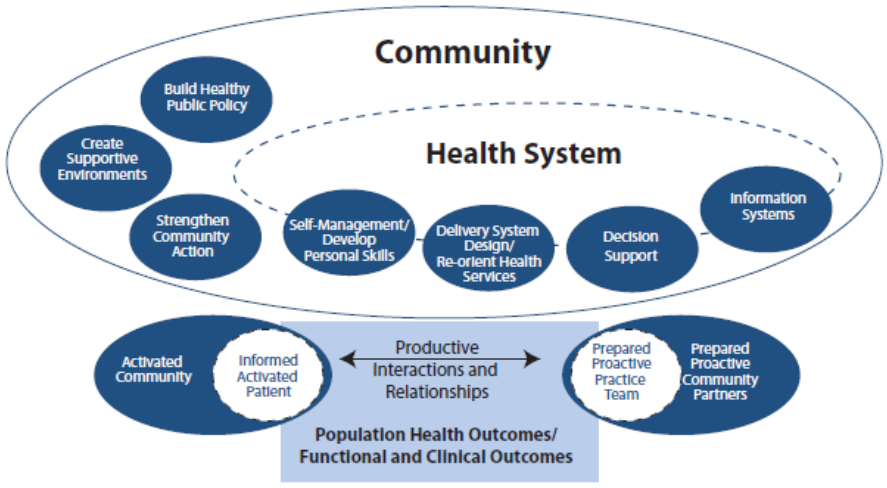
cholesterol, strokes, certain cancers, type-two diabetes, obesity, osteoporosis, and osteoarthritis' (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). Furthermore, physical activity also promotes psychological (i.e., emotional, cognitive, and social) wellbeing where the type of activity and the quality of experience, not the energy expended, were the main determinants of the psychological benefits. (Kerr, Rosenberg, & Frank, 2012) (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012; Coleman & Iso-Ahola, 1993).

Promoting Population Health

The healthcare system is but one of many routes to health promotion and maintenance (Government of Canada, 1974). Effective strategies for the prevention and management of chronic diseases requires an integrated approach that applies due consideration to social determinants of health (Government of Canada, 1974).

Figure 1. The Expanded Chronic Care Model

Figure 2. The Expanded Chronic Care Model: Integrating Population Health Promotion



Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002) Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association.(1986). Ottawa Charter of Health Promotion.

Self-Management / Develop Personal Skills	Enhancing skills and capacities for personal health and wellness	• Smoking prevention and cessation programs • Seniors' walking programs
Decision Support	Integration of strategies for facilitating the community's abilities to stay healthy	• Development of health promotion and prevention "best practice" guidelines
Delivery System Design / Re-orient Health Services	Expansion of mandate to support individuals and communities in a more holistic way	• Advocacy on behalf of (and with) vulnerable populations • Emphasis in quality improvement on health and quality of life outcomes, not just clinical outcomes
Information Systems	Creation of broadly based information systems to include community data beyond the healthcare system	• Use of broad community needs assessments that take into account: • poverty rates • availability of public transportation • violent crime rate
Build Healthy Public Policy	Development and implementation of policies designed to improve population health	• Advocating for / developing: • smoking bylaws • walking trails • reductions in the price of whole wheat flour
Create Supportive Environments	Generating living and employment conditions that are safe, stimulating, satisfying and enjoyable	• Maintaining older people in their homes for as long as possible • Work towards the development of well-lit streets and bicycle paths
Strengthen Community Action	Working with community groups to set priorities and achieve goals that enhance the health of the community	• Supporting the community in addressing the need for safe, affordable housing

Source: (Barr, et al., 2003)

The WHO defines health promotion as "the process of enabling people to increase control over, and to improve, their health [moving] beyond a focus on individual behaviour towards a wide range of social and environmental interventions" (World Health Organization, 2016). The Expanded Chronic Care Model (ECCM), a widely accepted model that combines healthcare and population health promotion approaches towards the prevention and management of chronic disease, clarifies and emphasizes the role of the community (Barr, et al., 2003). The sports and recreation sector could possibly contribute to one, if not all, of the seven ECCM-identified functions (see Fig 1). The potential role for the sport and recreation sector in population health

promotion is widely recognized; several developed nations are making investments in the sector (Casey, Payne, Eime, & Brown, 2009).

A Role for Older Adults Recreation Standards

The population projection for Canada signals a significant rise in the demand for older adult healthcare and social services in the coming decades. In principle, the sport and recreation sector is uniquely aligned with WHO's Global Strategy for Action Plan and CIHR-commissioned National Seniors Strategy to promote healthy ageing and active lives. In 2015, CPRA's framework for recreation in Canada was endorsed by the Provincial and Territorial Ministers responsible for physical activity and recreation (excluding Quebec) and supported by the Government of Canada (see Fig. 2) (Canadian Parks and Recreation Association, 2015). The framework articulates its vision as "a Canada in which everyone is engaged in meaningful, accessible recreation experiences that foster: individual wellbeing, community wellbeing, the wellbeing of our natural and built environments" (Canadian Parks and Recreation Association, 2015). Three out of the five key principles of operation towards this vision focus on the need for recreation to be outcome-driven, evidence-based, relevant and of as high quality as possible (Canadian Parks and Recreation Association, 2015). Recreation standards can play an important role in setting best practices and supporting these key principles of operation. Furthermore, recreation standards may also serve to encourage the fostering of partnerships and innovation. For example, the CPRA identifies HIGH FIVE® as the "best practice in quality assurance programming for recreation and sport programs for children aged 6-12" (Canadian Parks and Recreation Association, 2015). Similar best practice standards for older adult recreation programs that support the values, principles of operation and goals of the framework are also much needed.

Figure 2. The Framework for Recreation in Canada (retrieved from (Canadian Parks and Recreation Association, 2015))

Several constraints limit the assessment of efficacy and effectiveness of older adult recreation programs in achieving desired outcomes. Firstly, the older adult population is characterized by multifaceted diversity (e.g. age, culture, functional ability). Secondly, recreation activities are delivered in various forms; they can be formal or informal, structured or unstructured, indoor or outdoor, passive or active, group-based or solitary. Thirdly, recreation activities are offered by diverse providers from the public, private and not-for-profit sectors. The aforementioned and several other factors, such as economic means, can influence an individual's preference for one type of recreation activity over another and may, therefore, limit the assessment of a recreation program's intrinsic benefits. The most glaring constraint, however, is the absence of

established outcome-driven quality standards by which to assess the impact of sport and recreation programs in the quality of life of older adults.

Table 4: Where do Older Adults recreate?

ServiceOntario guide (2014) Informal sources (websites)	• Community and seniors' centres, cultural centres, adult day programs, service clubs (e.g. YMCA, Rotary club, Royal Canadian Legion), parks, senior events (e.g. senior games) • Educational facilities (e.g. Ryerson University acting classes), other clubs and societies (e.g. Humber Senior Curling Club, Toronto Swing Dance Society).

In Canada, the lead role of local government as the provider of recreation services is underscored by the large proportion of financial resources allocated to the sector (e.g., $9.189 billion in 2008) (Canadian Parks and Recreation Association, 2015). The size of the allocated funds provides reason for further emphasis on establishing relevant standards and monitoring of efficacy and effectiveness of programs. See Table 5 for a list of benefits of standards.

Table 5. Benefits of Standards

Benefits for the public:
• Demonstrates commitment to:
  • Improving quality and safety
  • reducing risk
  • Increasing efficiency and decreasing costs
  • Implementing best practices
• Assurance and validation of well-administered services in accord with (nationally accepted) approved professional practices
• Potential for external financial support and savings to the public
• External recognition of a quality governmental service
• Holds an agency accountable to the public and ensures responsiveness to meet their needs
• Improves customer and quality services

Benefits for the agency: • Public and political recognition • Increased efficiency and evidence of accountability • Answers the question, "How are we doing?" through extensive self-evaluation • Identifies areas for improvement by comparing an agency against national standards of best practice • Enhances staff teamwork and pride by engaging all staff in the process

- Creates an environment for regular review of operations, policies and procedures, and promotes continual improvement
- Forces written documentation of policies and procedures

Adapted from: (National Recreation and Park Association, n.d.) & (Accreditation Canada, n.d.)

The ISO defines a standard as "a document that provides requirements, specifications, guidelines or characteristics that can be used consistently to ensure that materials, products, processes and services are fit for their purpose" (ISO, n.d.). By benchmarking priorities and setting minimum requirements, standards can set a platform for the implementation of WHO's GSAP 5th strategy of 'improving measurement, monitoring and research on healthy ageing' and can offer foundational support to wellness and prevention programs as outlined in the 2nd pillar of the National Seniors Strategy's. From the perspective of the Expanded Chronic Care Model, standards promote population health by forming an infrastructure for evidence-gathering from health and wellness promotion strategies at the community level and facilitating decision support. Furthermore, cross-functional guidelines/standards when available could also facilitate the integration of clinical and population health outcomes through use of information systems, and subsequently, support research and guide policy formation.

The paragraphs above establish the importance of standards for older adult recreation, however, to our knowledge, none exist. The ISO offers published resource that outlines environmental factors and intrinsic capacities to consider when developing standards for services tailored to older adults and people with disabilities (see Table 6). 'Accessible Design' is another concept developed by the ISO with the aim to extend Universal Design to account for a broader range of individual abilities as well as design principles (ISO/IEC, 2000). Accessible Design may be defined as "the process of extending mass market product design to include people who, because of personal characteristics or environmental conditions, find themselves on the low end of some dimension of performance e.g. seeing, hearing, reaching, manipulating" (ISO/IEC, 2000). Such consideration is supported by WHO's promotion of age-friendly communities, i.e., "adapted environments and services that are accessible to, and inclusive of, older people with varying needs [to] encourage them to engage more frequently in community

activities." As part of a platform to support the Decade of Healthy Ageing, this is a favorable time for the development of quality standards for older adult recreation programs.

Table 6. ISO Guideline for the development of standards for older adults

Factors to Consider / Environments	Older Persons abilities / Intrinsic capacity
• General • Alternative format • Location and layout of information and controls and positioning of handles • Lighting levels and glare • Colour and contrast • Size and style of font and symbols in information, warnings and labelling of controls • Clear language in written or spoken information • Graphical symbols and illustrations • Loudness and pitch of non-spoken communication • Slow pace of information presentation • Distinctive form of product, control or packaging • Ease of handling • Expiration date marking • Contents labelling and warning of allergens • Surface temperature • Accessible routes • Logical process • Surface finish • Non-allergenic/toxic materials • Acoustics • Fail-safe • Ventilation • Fire safety of materials	• General • Sensory abilities • Physical abilities • Cognitive abilities • Allergies

Source: (ISO/IEC, 2001)

HIGH FIVE® Principles for Older Adult Recreation Programs

To our knowledge, there are no existing outcome-driven quality standards for older adult recreation programs.

In light of the absence of standards for older adult recreation, a broader look at possibly relevant standards published by organizations that offer accreditation/certification specific to senior centers, or senior specific programs and services was taken (Table 7). For comparative details between the organizations, see (Appendix A). Information from the organizations listed below that was accessible via the internet at no cost is used; it is, therefore, to be noted that the information is not exhaustive (Appendix B).

1. Accreditation Canada
2. National Council on Aging (NCOA)
3. National Recreation and Park Association (NRPA)
4. North Carolina Health and Human Services (NCHHS)
5. CARF International (CARF Canada, CARF Europe)

Table 7. Accrediting/Certifying Bodies for Older Adult Programs

It is proposed that HIGH FIVE®, a nationally recognized quality assurance standard for programs for children between 6-12 years of age, can serve as a model for the development of a quality assurance standard program for older adults. After all, although aging is invariably associated with physiological decline, it does not have to prevent older adults from developing "new interests, talents, and different aspects of [our] intellectual capacity, such as emotional, interpersonal, and creative intelligence" (Yarnal & Qian, 2011). The sub-sections below will highlight literature support for the application of the HIGH FIVE® principles in older adult

development and identify areas of overlap with standards from the aforementioned organizations.

It is also noteworthy that the HIGH FIVE® principles are well-aligned with the WHO-initiated Global Age-Friendly Cities Project which identifies eight characteristics of age-friendly communities that have impact on health ageing (See Table 8). Arguably, older adult recreation programs can function as small scale communities and should therefore, emulate relevant characteristics of age-friendliness.

Table 8. Eight characteristics of age-friendly communities

Characteristic	WHO definition	Applicable HIGH FIVE principle(s)
Respect and social inclusion	Are public services, media and faith communities respectful of the diversity of needs among older persons and willing to accommodate?	G1. Diversity G3. Developmentally appropriate
Social participation	Do elders have opportunities that allow for the development and maintenance of social networks within their neighbourhood?	P2. Friends P3. Participation P4. Play
Civic participation & employment	Do older persons have opportunities to participate in community decision making and employment and volunteerism that caters to their abilities and interests?	P5. Mastery
Outdoor spaces & buildings	Can older persons get around easily and safely in the community?	G2. Safe
Housing	Do older persons have homes that are safe, affordable, and conveniently located while promoting independence as the functional needs change?	
Transportation	Can older persons travel wherever they want to go in the community, safely and in an accessible and affordable way?	
Communication & Information	Are older persons and their families aware of the diverse range of programs and services available within their community and communicated to in accessible ways?	P1. A Caring Adult
Community & Health support	Do older persons have access to social and health services they need to stay healthy and independent?	P1. A Caring Adult

Principle 1. Older Adult Leader/Support

Adherence to physical activity among the older adult population is influenced by many complex, and inter-dependent factors. An older adult leader may play an important role in mediating and moderating the influence of these factors to achieve desirable outcomes. Critical functional roles of an older adult leader that could significantly impact participation in sport and recreation activities include, but are not limited to, initial needs assessment, screening for readiness, understanding and implementing evidence-supported components of successful intervention, and addressing barriers.

Recommendations for physical activity for older adults tend to be based on scientific evidence for healthy older adults without regard for other prevalent, and potentially significant, moderating factors (Brawley, Rejeski, & King, 2003). However, the heterogeneity of the older adult population implies that determinants of physical activity are also diverse. For example, a growing body of literature identify cultural background as a determinant of physical activity among older adults. Another determinant is mood state; depression has been shown to be a significant predictor of use of social and recreational services (Badger, 1998). An older adult leader can perform needs assessment to identify factors relevant to the population served with the purpose of adjusting activities or providing support as needed. Towards this aim, the WHO-developed International Classification system of Functioning, Disability, and Health (ICF) framework is one tool that may be used as a scientific standardized tool for the assessment of level of functioning, outcomes of intervention, self-evaluation at the individual level, for training and education, resource planning and development, quality improvement, outcome evaluation at the institutional level, and for eligibility assessment, needs assessment, environmental assessment identification of facilitators and barriers at the societal level (World Health Organization, 2002). The ICF is also a useful framework for standardizing language across medical and social contexts, an objective aligned with the Expanded Chronic Care Model for population health promotion. Furthermore, it may serve as a useful framework for research on disability in aging as it measures physical impairments, level of capacity, and level of

performance, i.e., participation (Rejeski, Ip, Marsh, Miller, & Farmer, 2008; World Health Organization, 2002).

Promoting active living among older adults requires the willingness of those individuals to participate in physical activities. It is, therefore, necessary to screen for readiness and adjust recreation programs accordingly. Several psychological and behavioural change models such as transtheoretical model and precaution adoption process model may be used to explain the state of readiness (Brawley, Rejeski, & King, 2003). These models could guide the assessment of degree of fit with the program design, i.e., the intervention. For example, the transtheoretical model of health behaviour, a valid framework for use in older adult population, categories stages of readiness into pre-contemplation, contemplation, preparation, action and maintenance where some activity begins at the 'preparation' stage, meets recommended guidelines for under 6 months at the 'action' stage and identifies activity for over 6 months as the 'maintenance' stage (Dacey, Baltzell, & Zaichkowsky, 2008).

An older adult leader is in a unique position to assess factors that determine the appropriateness of a recreation program. One such factor is location/geography. For instance, a study showed that older adults in lower density neighbourhoods in the cities of Vancouver and Portland preferred to spend leisure time at parks or beaches whereas those who lived in higher density neighbourhoods in Portland favoured gardening (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). Another factor is the design of the recreation program. For example, older adults who experience loneliness would most likely benefit from structured versus unstructured activities (Jancey, et al., 2007; Cattan, White, Bond, & Learmouth, 2005). Studies have shown significant reduction in loneliness in programs that implemented structured physical activity perhaps as a result of improved social support and happiness (Jancey, et al., 2007). As another example, overweight individuals are reportedly less likely to adhere to high-intensity programs (Jancey, et al., 2007). Exercise interventions that are not compatible with perceived or actual internal capacity and outcome expectation are associated with attrition (Jancey, et al., 2007). Other factors that could be considered include clarity and consistency of

instruction, as well as frequency, intensity, time of exercise programs and duration of programs (Jancey, et al., 2007).

An older adult leader could play a critical role in the proper implementation of evidence-based behavioural strategies to deliver an effective intervention. Older adults have had a long time to accumulate maladaptive health behaviours. Behavioural change intervention is therefore an important element of promoting physical activity in this population. In the Social Cognitive Theory of self-regulation, it is posited that "human behaviour is extensively motivated and regulated by the ongoing exercise of self-influence" (Bandura, 1991). It is important that older adults own causal responsibility and gain courage to make positive behavioural changes. Some models of *self-regulation* include self-monitoring, goal-setting towards meaningful rewards, corrective feedback, and conditional reinforcements to support desired behaviour or progress. Self-regulation can also be encouraged through behavioral contracting (i.e., a negotiated agreement) or commitment enhancement methods (i.e., disclosure of commitment to significant others) (Brawley, Rejeski, & King, 2003). Self-regulatory skills are necessary to encourage success in behaviour change. These include (1) problem-solving and planning skills (e.g. to evaluate success, to revise/adapt when needed); (2) intra- and inter-personal skills (e.g. to gain cooperation/support); (3) skills to manage deviations (e.g. non-adherence to exercise); and (4) attribution-retraining skills (i.e., to accept responsibility) (Brawley, Rejeski, & King, 2003). An older adult leader with sufficient knowledge base could empower older adults through self-regulatory models/skills.

A review of randomized-controlled studies assessed the effectiveness of instructor-led, center-based physical activity programs for healthy older adults and found that those that implemented behavioural strategies such as *self-efficacy* and team building interventions were effective (Brawley, Rejeski, & King, 2003). Self-efficacy is significantly related to older adult engagement in recommended levels of leisure time physical activity among older adults (Orsega-Smith, Payne, Mowen, Ho, & Godbey, 2007). Self-assessment of intrinsic capacity could therefore determine the likelihood that an older adult would engage in a particular type of

physical activity and would also determine the extent to which the individual would persevere in the face of constraints. Past history of physical activity has been shown to predict likelihood for exercise adherence. A possible explanation is that those with history of physical activity had higher self-efficacy (Jancey, et al., 2007). Lower self-efficacy, for reasons that include poor history of physical activity and fear of injury and illness, may be predictive of likelihood of attrition (Jancey, et al., 2007). Self-efficacy, however, can be bettered. Successful participation is reported to improve perception of self-efficacy (Jancey, et al., 2007). An older adult leader can make an early assessment of factors that affect self-efficacy and tailor activities in a way that removes barriers and empowers participants.

Self-efficacy largely determines outcome expectation, i.e., "the types of outcomes people anticipate depend largely on their judgements of how well they will be able to perform in given situations" (Bandura, 1986). In turn, outcome expectation appears to largely determine motivation. Intrinsic (i.e., emotional enjoyment) and self-determined extrinsic motivation (i.e., health and fitness, stress management, and socio-emotional benefits) are reported to be positively associated with higher levels of and commitment to physical activity whereas non-self-determined extrinsic motivation (e.g., weight management and appearance) was not associated with behaviour change (Dacey, Baltzell, & Zaichkowsky, 2008). The findings from this study suggest that the focus of an intervention can have a significant impact on older adult participation in physical activity (Dacey, Baltzell, & Zaichkowsky, 2008). Perhaps programs that focus on enjoyment are more likely to be successful compared to those that focus on weight management.

Where appropriate or necessary, an older adult leader may be in a unique position to interact with and encourage the participation of families and friends of older adults in various activities. Studies have shown that family support for and involvement in older adults' leisure-time physical activities is positively associated with levels of life satisfaction and favorable health behaviours (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006)

The attitudes and expectations of social agents, including those of an older adult leader, have a significant impact on the adoption of exercise programs, perseverance through constraining circumstances, and achievement of desired outcome by older adults. The Theory of Planned Behaviour suggests that one of several factors that influence intention is perception of social acceptability and pressure to conform to social norms (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). Research shows that older adults who might have received social support, i.e., "verbal encouragement from friends, peers, or exercise programme leaders" had higher self-reported physical self-efficacy scores (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). Studies have also repeatedly documented the association between perceived or anticipated support and overall wellbeing of older adults. While considering the significance of support for successful older adult recreation, it is important that the older adult leader is aware of the risks of empathy fatigue and is equipped with resources and skills for self-replenishment (Van Winkle, Fjortoft, & Hojat, 2012). After all, while positive social ties have a buffering effect on psychological distress, negative ones worsen the effect (Okun, Melichar, & Hill, 1990). Negative daily events are stronger predictors of on the depression symptomatology of older adults as compared to negative major events (Okun, Melichar, & Hill, 1990). Negative interpersonal interactions rising from biased assumptions about aging may count as negative events.

An older adult leader can be an important player in dispelling and combatting the detrimental effects of myths about aging. The Public Health Agency of Canada (2014) reported, "There are several myths associated with an aging population including that: mental and physical deterioration can be expected, healthcare is a primary issue for older persons, investment in older people is a waste of resources, older workers take away jobs from younger people, and all older people have similar needs" (Public Health Agency of Canada, 2014). Such myths can have dire effects on intergenerational communication, including between older adult leader and older adult (Ryan, Hummert, & Boich, 1995). For example, "oversimplified speech, baby talk, or ignoring" stemming from biased perceptions of an older adult's capacity may be perceived as lack of respect. Furthermore, "over-accommodation in communication with older adults based on stereotyped expectations of incompetence and dependence" often go hand-in-hand with

"under-accommodation to the individual needs of the recipient". A behavioural consequence of such patronizing communication is the reinforcement of behavioural deficits, a sense of declining capacity and loss of control. A psychological consequence is that others may draw inaccurate conclusions about the capacities of older adults rather than becoming aware of the issues with this form of communication. An older adult leader should make use of available resources such as guideline for acceptable intergenerational communication developed by the American association for retired persons (1984) to ensure that their behaviour serves to empower older adults (Ryan, Hummert, & Boich, 1995).

An older adult leader is responsible for creating a space that is welcoming of diversity. For example, LGB individuals reported satisfaction with the support received when their sexual orientation is known to members of their social network highlighting the benefits of social safety (Masini & Barrett, 2008). An older adult leader is also responsible for the safety of the recreational environment. For example, older adults are differentially affected by chemicals and environmental pollutants, therefore, environment safety is critical. Traffic pollution has also been recognized as risk factor for heart disease and stroke among older men (Hong, 2013).

Accreditation Canada: provides a plans and framework guide for community needs assessment, albeit not specific to recreation programs. The guide recommends consideration of demographic variables, determinants of health, risk factors, and feedback from clients and community.

NCOA: under its standard for program planning, recognizes the importance of responding to the needs and interest of older adults as well as their families and caregiver taking into consideration the range of physical, cognitive, and cultural diversity as well as geographical features.

CAPRA: highlights the need for community involvement in planning.

CARF: recognizes the need for assessment of accessibility needs and removing barriers such as attitudinal concerns.

BCRPA: outlines standards for older adult leadership including knowledge of the aging process, leadership and communication skills, exercise analysis and risk management skills, program planning skills, program organizing skills, use of music, and ongoing personal professional development.

NCHHS: under standards for operations and program evaluation, the need for input from older adults is indicated.

Principle 2. Friends

"For older adults, having a strong social network of family, friends, neighbors, and co-workers often means the difference between health and morbidity" (Masini & Barrett, 2008).

Social Benefits

Social relationships, including those related with leisure activities, are important contributing factors to the psychological health, self-reported happiness, life-satisfaction and overall wellbeing of older adults (Gilmour, 2012). Social relationships have been shown to reduce risks of mortality, disability, loneliness and depression as well as contribute to cognitive health in older adults (Masini & Barrett, 2008; Gilmour, 2012).

Although older adults recognize the support of adult children, friendship-based social support plays a unique role in promoting resilience in the older adult population (Wiles, Wild, & Kerse, 2012). Older adults report that interactions with friends allow them to transcend "mundane daily activities" and are, therefore, more favorable experiences (Larson, Mannel, & Zuzanek, 1986). This observation is supported by the socioemotional selectivity theory which suggests that older adults show a higher likelihood of reaching out to friends for companionship and support (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). This may in part be because family members are often younger, may not relate well to the circumstances of the older adult and may therefore not be equipped to provide the kind of support that a friend could offer (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). Furthermore, the voluntary nature of friendships is said to preserve an older adults' sense of significance and self-esteem (Chappell, 1983). The value of friendships is further emphasized in sexual minority groups; compared to their heterosexual counterparts, LGB older adults are reported to depend more on friends and partners rather than family for support (Masini & Barrett, 2008). Social support from friends, and not from family, was found to have predictive power on psychological outcomes including "depression, anxiety, and internalized homophobia, illustrating the protective mental health effects of friendships" (Masini & Barrett, 2008).

Several studies show the potential for the development and nurture of close friendships through leisure and physical activities (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). In one study, all participants reported that socializing and peer support occurred during and after structured (e.g. exercise program) and unstructured (e.g. gym workout) physical activity (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). A separate study showed that women who lived alone, compared to those who lived with their spouses, formed "social network that extended outside of the center environment" by virtue of their higher participation rates in leisure activities (Aday, Kehoe, & Farney, 2006).

The quality of social support is more significant than the size of social network. This is evidenced by research findings that while the number of social activities participated in was positively associated with self-perceived health, and negatively associated with loneliness and life dissatisfaction, these association were no longer observed in the absence of positive social interactions (Gilmour, 2012). Quality of social support is influenced by both actual and perceived support. Evidence further suggests that perceived support related to leisure activities mitigates the deleterious effects of stress on health more robustly as compared to actual support (Gilmour, 2012).

Motivate Physical Activity

Studies have shown that social support was a strong predictor of continued participation in leisure activities (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006; Cousins, 1995). Research shows that instrumental and emotional social support from friends increases participation in leisure physical activity (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). Instrumental support such as joint participation and scheduling physical activity as well as emotional support via comfort and encouragement improve participation in leisure physical activity. Furthermore, joint participation has been shown to improve life satisfaction suggesting that leisure physical activities are linked to meaningful interpersonal relationships (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). A conceptual model of the relationship between participation in and

being loyal to leisure activities hypothesizes that 'social support and anticipated benefits (friendship and kinship)' are strong factors that 'influence the formation of individuals' involvement with recreational activities or products' (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). A case in point is the finding that women differentially reported unwillingness to travel alone to participate in activities (Gilmour, 2012). It has also been reported that social support plays a key role in the development of an 'individuals' psychological commitment toward their primary recreation service providers' (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006).

Interestingly, family support may not have significant effect on the level of participation in physical activity but may contribute to overall older adult satisfaction (Orsega-Smith, Payne, Mowen, Ho, & Godbey, 2007; Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). Research suggests that older adults experience greatest satisfaction in both indoor and outdoor recreational activities when participating with age-peer friends as compared to family members (Chappell, 1983). Furthermore, family support appears to encourage older adults to engage in home-based and indoor exercise, perhaps because of fear of injury. Family support is, therefore, limited in its impact on physical wellbeing, although it may be beneficial for mental wellbeing, and better functioning of older adults (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). On the other hand, support from friends may encourage more strenuous forms of physical activity (Sasidharan, Payne, Orsega-Smith, & Godbey, 2006). A possible explanation is that social support for leisure participation, especially from friends, promotes self-efficacy and outcome expectation in older adults.

Principle 3. Participation

Several factors may facilitate or serve as barriers to full participation of older adults in sport and recreation activities including those indicated below.

Access to information is identified as a concern to older adults (Bryant, et al., 2004). Many older adults rely on word of mouth communication from their personal networks as the primary source of information and help (Walker, et al., 2016). Information related to programs and services available to older adults should be diffused via accessible mediums and formats with due consideration of the difference in characterization of accessibility across communities (Bryant, et al., 2004). Accessible mediums may include mass-media advertising, direct mail, personal contacts as well as online access designed to circumvent the confusion that is associated with internet searches (Walker, et al., 2016; Cattan, White, Bond, & Learmouth, 2005). Accessible format would take into account readability and comprehensibility of information (Bryant, et al., 2004).

The higher prevalence of mobility impairments among older adults underscores the importance of physical accessibility of programs and services, and availability of public transportation to the destinations for sport and recreation (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). Perception of proximity is associated with increased overall physical activity (Kerr, Rosenberg, & Frank, 2012; Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). Where proximity is not an option, ease of access to public transportation to recreational places including parks is critical (Bryant, et al., 2004). Women are differentially affected by transportation problems (Gilmour, 2012). Therefore, when developing community programs, it is important to consider the need for and availability of transportation services as well as the possibility of utilizing existing infrastructure in proximal community to offer services that have higher likelihood of reaching the target population (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012).

Older adult engagement is another important factor for participation in sport and recreation. Ageism and the consequent biased assumptions of the capacity of older adults act as a significant barriers to the reception and serious consideration of their thoughts and opinions (Bryant, et al., 2004). However, older adults would like for their opinions to be valued, for their political voices to be heard and to be consulted in decision-making processes that affect their well-being and overall quality of life (Bryant, et al., 2004). From the perspective of sport and

recreation programs for older adults, older adult engagement and feedback can be useful to keep the programs relevant and effective.

Aesthetics play a role in motivating physical activity (King, 2001; Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). For example, one study reported that women over 50 years of age were more active in areas of beautiful scenery and residential neighbourhoods as compared to "mixed-use neighbourhoods" (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012).

Feelings of safety are also critical factors for the participation of older adults in sport and recreation activities. From the perspectives of older adults, physical and psychological security are encouraging elements of mobility in neighbourhoods (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). The following are some barriers to mobility in neighbourhoods: uneven, narrow or even absent sidewalks, absence of sufficient lighting or seating benches, high pedestrian traffic, as well as traffic hazards such as unsafe intersections and poor visibility (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012). Factors that promote 'comfort of movement' and physical activity include 'railings, handrails, ramps, safe stairs, and water fountains,' clean washrooms and automated doors in buildings as well as safe paths and restrooms in parks (Chaudhury, Mahmood, Michael, Campo, & Hay, 2012).

Older adults' also have a unique perspective on security that ought to be considered. Research shows that older adults associate open public spaces with vulnerability and, therefore, prefer supervised environments such as recreational facilities or environments where they feel that they are less likely to be harmed due to the presence of others (Kerr, Rosenberg, & Frank, 2012). For example, presence of a group of young individuals, particularly at nightfall, may be perceived as a threat and may, therefore, deter mobility in public spaces (Kerr, Rosenberg, & Frank, 2012).

Accreditation Canada: identifies the need for developing communication and client safety plans. It is further suggested that an outcome evaluation is conducted for the assessment of the success of communicated strategies. To further client safety, it is suggested that a multidirectional feedback and learning systems including coaching and mentoring are included. Other safety-related standards include infection control and risk assessment.

NCOA: also highlight communication (under governance) and safety. Additionally, it encourages the collaboration with other community service providers (under community) to increase accessibility of services and to enhance responsiveness. Furthermore, the need for outreach and marketing strategies is also indicated.

CAPRA: identifies the needs for risk management plan and procedures. 'Outreach to diverse underserved populations' is also recognized.

NCHHS: the need to address transportation to the center as well as marketing to special populations is recognized.

CARF: addresses communication and safety of persons served. Communication is further qualified to indicate the need to communicate the rights of the persons served. Furthermore, it highlights the need for a 'system of rights that nurtures and protects the dignity and respect of the persons served'. Safety measures are also addressed in great detail including written procedures for several types of critical incidents, risk management, and standard and universal precautions.

Principle 4. Play

A dearth of research on the impact of play on the quality of life of older adults limits our understanding of play's role in older adult recreation. The role of play is highly contested, some researchers argue that it serves no purpose whereas others argue that it has an important role in the development and maintenance of physical, cognitive as well as social functioning (Yarnal, Chick, & Kerstetter, 2008). However, the following information suggests that play can contribute to the psychological wellbeing of older adults.

An online survey-based study used evolutionary-based explanations to describe the role of play in older women. Participants were recruited from the Red Hat society, an international organization of women over the age of 50 that promotes fun, friendship, freedom, fulfillment and fitness. The finding supports that play indicates neoteny in older adults, i.e., the retention of traits associated with childhood, or deferred self-fulfillment, where play was described as

social, voluntary, non-serious, experimental, and creative, and occurs in a safe environments. Play supported the cultivation of friendships and positive emotions such as "joy, pleasure, enjoyment, love, and bliss" among older women. Findings also showed that fun is fundamental for play where fun meant "freedom from a constellation of factors like worry, responsibility, loneliness, isolation, stress, and depression" as well as "boisterous, loud, effusive, spectacular, publicly expressive, shared, and collective forms of playful self-expression, which several women remarked as "unusual" for older women" (Yarnal, Chick, & Kerstetter, 2008).

Humor is reported to have positive impacts on health and wellbeing. Humor is also an element of neoteny, i.e., "growing young" (Simon, 1988). Although well-studied in infant and adolescent populations, the role of humor in healthy aging is under-researched. Psychological theorists suggest that humor is an adaptive coping mechanism. Humor helps release negative emotions and promotes relaxation and well-being. In older adults, a sense of humor may indicate resolution of one's conflicts with the ego. Humor can ease the adjustment to changes that come with age and divert focus on positive pursuits of growth and development. Laughter, too, has benefits to health. From a physiological perspective, laughter "increases respiratory activity and oxygen exchange, muscular activity and heart rate, the sympathetic nervous system" leading to the production of endorphins, i.e., natural pain and stress fighter chemicals, and subsequently, reduces blood pressure (Simon, 1988).

Although lacking in empirical evidence, some researchers have claimed that play associated with positive affective state may contribute to healthy ageing via its positive effects on cognitive functioning and emotional health/growth. Play is also posited to contribute to psychological resilience. Yarnal and Qian (2011) characterize playful adults as cognitively spontaneous, creative and whimsical. They suggest that playfulness is cannot simply be identified as a trait, rather, it is "an attitude of throwing off constraint" (Yarnal & Qian, 2011). Also, older-adult playfulness is not necessarily physical in nature and tends to be moderated by context (Yarnal & Qian, 2011). Fifteen descriptors that may serve as reliable and valid measures of older adult playfulness were identified: happy, optimistic, cheerful, joyful, positive, relaxed,

enthusiastic; mischievous, naughty, clowning, teasing; creative, whimsical; funny, humorous (Yarnal & Qian, 2011). This observation suggests that it is possible to deliberately and successfully foster an environment that promotes playfulness among older adults.

Principle 5. Mastery

From the perspective of older adults, a sense of mastery may be achieved not only through the pursuit of knowledge and new skills but also through the use of existing knowledge/skills to contribute to the community.

The WHO identifies lifelong learning as a key element of active ageing (Jenkins & Mostafa, 2015). In spite of the cultural bias against later life learning and the misconception of learning as a means to gainful employment alone, learning continues to occur at all ages, regardless of health status and in spite of changes in capacity (Weinstein, 2004; MacNeil, 1998). Older adults who participate in lifelong learning not only acquire new information and strengthen their cognitive capacity but also have increased opportunity to enhance their ability to cope, as well as to meet their needs for expression, contribution and influence (Hafford-Letchfield, 2010; MacNeil, 1998; Weinstein, 2004; Narushima, 2008). Furthermore, lifelong learning can have mitigating effects on "depression, anxiety, boredom, and preoccupation with physical complaints" which are commonly occurring conditions among older adults (MacNeil, 1998). Notwithstanding the compelling evidence for its benefits, lifelong learning significantly declines with age with level of education being a predictive factor (Statistics Canada, 2008). The primary motivation for older adults to engage in learning is the pursuit of personal interest. Other motivations include personal growth, satisfaction, accomplishment, and social activity (Statistics Canada, 2008; Narushima, 2008; Kim & Merriam, 2004).

Recreation centers are well-positioned to offer lifelong learning opportunities that are more accessible to a wider population of older adults, e.g., those with lower levels of education and therefore, less likely to engage in learning activities, through non-formal learning programs.

Non-formal learning is defined as “any organized educational activity outside the established formal system-whether operating separately or an important feature of some broader activity that is intended to serve identifiable learning clienteles and learning objectives” (Arsenault & Anderson, 1998). Lifelong learning programs can include “art history, religion, literature, philosophy, painting, computers, yoga” or may be “field trips such as visits to museums, historical sites, and cultural events” (Weinstein, 2004). They may also focus on physical health related activities such as “folk dancing, walking, swimming, tennis, or aerobics” (MacNeil, 1998).

Masters sports is also gaining in popularity as an area of mastery among older adults as can be seen in the growing numbers of older adults participating in sporting events such as World Masters’ Games and Senior Sports (Lyons & Dionigi, 2007). A qualitative study identified the following initial motives, be it individually or in combination, for the observed trend: ‘the desire to actively resist the dominant negative stereotypes associated with aging, the need to feel empowered to live a fulfilled and healthy life, a desire to delay as long as possible the negative effects of old age, and a desire to experience community is also a key motivator for older adults who participate in sports’ (Lyons & Dionigi, 2007). The study also found four main themes around the psychological sense of community that developed in these environments which include: membership, shared emotional connection, fulfillment of needs in terms of acknowledgement of accomplishments, and giving back in the form of coaching and volunteering in their area of sports (Lyons & Dionigi, 2007). When such peer-coaching opportunities are facilitated, a positive feedback loop may develop. For example, the results from one study in the female older adult population suggested that “a better way to reach many older women is to expand the social networks of currently active women who would be willing to lead sedentary adults into more active lifestyles” (Cousins, 1995). Furthermore, peer volunteers can play a significant role in the long term adherence to physical activity among older adults (Buman, et al., 2011).

Some older adults may engage in sports in a purpose-driven manner as indicated above, yet others' engagement may be better explained by a career-like trajectory (Heuser, 2005). A researcher observed the following stages: introduction to game, attachment to the game, playing, participating organizationally and, later, retiring from the game. This path was not linear and, depending on life circumstances, periods of changes in commitment to the game i.e., social, serious or temporarily retirement from game, occurred.

Older adults may also experience a sense of mastery through continued community involvement, including volunteering opportunities. Compared to volunteers of other age groups, older adults who volunteer are generally more committed to their volunteer roles as evidenced by more time spent in the role for longer periods of time (Onyx & Warburton, 2003). A document published by the Government of Canada in 2014 reports that 36 percent of older adults contributed an average of 223 hours in volunteer hours where the national average is 156 hours. In addition to offering older adults the opportunity to make meaningful social contributions, volunteering also offers several health benefits to older adults. Those who volunteer report better perceived health, psychological health and quality of life, overall personal well-being and exhibited lower risk of institutionalization (Onyx & Warburton, 2003). They demonstrated better self-esteem and ability to cope with life events (Onyx & Warburton, 2003). Those who volunteer also had reduced mortality rates independent of health habits, religious attendance and social support. The government of Canada's New Horizons for Seniors Program is a demonstration of the acknowledgement of the importance of volunteer opportunities for older adults. The program funds initiatives that serve the following objectives: "promoting volunteerism among seniors and other generations; engaging seniors in the community through the mentoring of others; expanding awareness of elder abuse, including financial abuse; supporting the social participation and including of seniors; and providing capital assistance for new and existing community projects and/or programs of seniors" (Government of Canada, 2016; Government of Canada, 2015). Such programs are aligned with desirable outcomes of the sport and recreation for older adults and can, therefore, serve as useful resources.

Volunteering opportunities can also be designed to promote intergenerational interactions. Older adult volunteers as well as the communities served can benefit from programs that promote intergenerational exchange through knowledge- and experience-sharing. Experience Corps is one model of health promotion for older adults that focuses on creating productive roles for older adults through a volunteer service program in public elementary schools. This model is based on theories of generativity at the individual level, and social capital at the group level, where generativity is 'the expansion of care beyond oneself, toward others, and transferring knowledge and wisdom to younger generations' (Glass, et al., 2004). Results from the pilot study showed that older adults exhibited improvement in physical, cognitive and social activity. The benefits were bidirectional; improvements in the school environment as well as children's reading scores and behaviour was observed (Fried, et al., 2004).

NCHHS Standards: Recognizes the availability of activities and opportunities for volunteering and advocacy as items to be considered in evaluating a program.

Final Remarks

Outcome-driven quality standards for older adult sport and recreation programs are necessary. From an individual and societal perspective, the importance of such standards is underscored by the unprecedented growth projections in older adult population, the associated increase in demand for sport and recreation programs and services, the significance of the individual and population health benefits associated with sport and recreation programs, and the role of quality of service on participation. From an economic perspective, considering the magnitude of financial resources invested in the sport and recreation sector on an annual basis and considering the extent to which well-delivered programs can alleviate the burden on the healthcare and public health sector, it is prudent to implement a system of checks and balances by ways of standards. The Public Health Agency of Canada identifies research on aging as

necessary “to support the enhancement of programs, services, policies and care” (Public Health Agency of Canada, 2014). Quality standards support research initiatives by fostering environments that are viable for gathering evidence.

At the level of sport and recreation programs, the HIGH FIVE® principles are well-positioned to serve as benchmarks for quality. The HIGH FIVE® principles are aligned with evidence from extant academic literature on the role of sport and recreation in the quality of life of older adults. The HIGH FIVE® principles are further supported by their alignment with the WHO-initiated Global Age-Friendly Cities Project which identified eight key characteristics of age-friendly communities that have impact on healthy ageing (See Table 8). After all, older adult programs may also be viewed as communities of smaller scale. Furthermore, HIGH FIVE® principles offer a framework for superior standards compared to those identified in Table 7, none of which address all five principles and only one addresses three, albeit insufficiently.

It is recommended that next steps include further in-depth evaluation of each principle via academic reviews of literature, qualitative research (i.e., interviews and focus groups) and subsequent development of practical methods of implementation in sports and recreation programs.

Older Adult Focus Groups - Factors to Consider:

- Demographic variables are important descriptors. However, it is important to note that they have not been found to be consistent predictors of participation in leisure activities.
- Cultural characteristics, geographic variables, health status should be gathered. Use of available guidelines such as the ICF for health status may be useful for data integration and research

- The population of older adults who are unwilling to participate may represent a unique group of older adults. Asking the reason for non-participation may be revealing (e.g., limitations in mobility).
- Number of questions to be posed and depth of responses desired should take into consideration the feasible length of participation time.
- Research has shown that inconsistencies in definition of terms limit interpretability of results. For example, it has been shown that falls are perceived differently by older adults and medical professionals. Similarly, terms such as impairment, disability, fun, friendship, and physical activity may have different meanings for different individuals. It is suggested that participants define terms used during the focus groups as a point of reference for understanding their response.

APPENDIX A

Organization	Relevant Target Clients	Process	Notes
Canada			
Accreditation Canada	* Community care * Seniors' care * Population Health and Wellness standards	* 2 year primer; 4 year full accreditation (Qmentum accreditation) **Decisions**: Accredited with exemplary standard; Accredited with commendation; Accredited	>70 healthcare and social services standards >300 organizations that provide service to older adults **Recognition:** Ontario LHIN and all provincial health authorities
United States			
National Council on Aging : National Institute of Senior Centers	* Senior centers * Special population designation to senior centers		151 standards (37 fundamental and 114 non-fundamental standards) > 200 senior centers
National Recreation and Park Association	* Parks and recreation agencies * municipalities, townships, counties, special districts and regional authorities, councils of government, schools, and military installations	* 5 year cycle (CAPRA accreditation) **Decisions**: Accredit, Accredit with conditions, Defer decision, Deny accreditation	141 park and recreation agencies
North Carolina Division of Aging *	* Seniors' centers * Adult day care services * Adult day health services	**Decisions**: Merit, Excellence	
International			
CARF International: CARF Canada CARF Europe	* Aging services (incl. Adult day services, Assisted living) * CCRC	* 3 year; 1 year; provisional, non-accreditation * CCRC: 5 year, non-accreditation, accreditation with stipulation	* 52,765 programs/services * Recognized by: incl. MOHLC, CCAC, Mississauga-Halton and Central West LHIN

APPENDIX B

Accreditation Canada: Required Organizational Practices:

Safety culture	• Accountability for quality • Patient safety incident disclosure • Patient safety incident management • Patient safety reports • Patient safety-related prospective analysis
Communication	• Client identification • The 'Do Not Use List' of abbreviations • Information transfer at care transitions • Medication reconciliation as a strategic priority • Medication reconciliation at care transitions • Safe surgery checklist
Medication use	• Antimicrobial stewardship • Concentrated electrolytes • Heparin safety • High-alert medications • Infusion pump safety • Narcotics safety
Worklife/Workforce	• Client flow • Patient safety: education and training • Patient safety plan • Preventive maintenance program • Workplace violence prevention
Infection control	• Hand-hygiene compliance • Hand-hygiene education and training • Infection rates • Pneumococcal vaccine • Reprocessing
Risk assessment	• Falls prevention • Home safety risk assessment • Pressure ulcer prevention • Skin and wound care • Suicide prevention • Venous thromboembolism prophylaxis

Accreditation Canada: Qmentum Plans and Frameworks Guide:

Community needs assessment	• Demographic information such as age, cultural diversity, literacy, and language • Impact of the determinants of health such as housing conditions and socioeconomic status • The rates of risk factors such as smoking or overweight/obesity • Feedback from clients and the community about their health needs
Strategic plans	• Formal, written document that defines the long-term direction of an organization as a whole. • Sets broad strategic goals and contributes to effective decision-making with regard to resource allocation or difficult operational choices. • Addresses broad questions such as: Who are we? Where are we now? What is the environment (physical, cultural, political) in which we operate? Where do we want to go, and how should we get there?
Operational plans	• Summarizes the activities to be undertaken in the coming year toward meeting the strategic goals, and identifies the necessary processes, actions, and resource • Breaks the broad strategic goals into smaller, more manageable pieces, each with their own operational objectives
Integrated quality management frameworks, including risk management	• Helps the organization develop and demonstrate a commitment to quality and safety at all levels. • To monitor and improve its quality of care and service over particular period of time • Framework should incorporate risk and utilization management; performance measurement, including monitoring of strategic goals; client safety; and quality improvement.
Ethics framework	• An analytical tool to helo guide ethical decision making. • Health care providers and administrators face many ethical and moral dilemma in the course of

	their work (e.g. care decisions, informed consent, research projects, resource allocation challenges, disclosure of risk).
Communication plans	• A written document that helps clarify who you want to reach with a particular message, what the message is, and how you are going to reach them. • It identifies: objectives, target audiences, key messages, strategies and timelines, outcomes • Including the outcomes evaluation component as part of the communications plan is a valuable way to assess whether the objectives have been achieved
Client safety plans	• To identify client safety issues within organization • To develop a client safety plan can identify steps that have been taken and that will be taken to address client safety issues. • Client safety may be improved by coaching and mentoring staff and service providers, leading client safety leadership walkabouts, implementing organization-wide client safety initiatives to promote widespread learning, accessing evidence and best practice, encouraging staff and service provider innovation, providing feedback to staff and service providers on client safety issues and safety improvement suggestions, recognizing staff and service providers for their suggestions to improve client safety, and acting on staff and service provider recommendation.
Disaster and emergency plans	• Outlines the steps and activities to be taken during a disaster or emergency. • Depending on the nature of the organization, the plan should address topics such as: notifying the police or other emergency services; isolating, evacuating, and relocating clients; deciding what services the organization can continue to deliver; and taking in mass casualties.

NCOA standards:

Purpose	• A written statement of its mission consistent with the senior center philosophy. • A written statement of its goals and objectives based on its mission and on the needs and interests of older adults in its community or service area. • A senior center shall have written action plans that describe how its program will achieve goals and objectives.
Community	• A senior center shall participate in cooperative community planning, establish service delivery arrangements with other community agencies and organizations, and serve as a focal point in the community. • A senior center shall be a source of public information, community education, advocacy, and opportunities for older adults. • By establishing relationships with other service providers, the senior center helps make the service system more responsive to older adults. When appropriate, encourage providers to deliver their services at the senior center in order to make their services more accessible to the community's older population. Or, arrange for the senior center to use the facilities of other organizations to provide services. • As a focal point and advocate for older adults, the senior center must provide information to the community and center participants about its programs and about aging issues. • As part of their role in the community, senior centers provide field training and educational opportunities for interns in the aging field.

	• To the extent practical and ethical, senior centers conduct or take part in research that advances knowledge about senior centers and aging.
Governance	• A senior center shall be organized to create effective relationships among participants, staff, governing structure, and the community in order to achieve its mission and goals. • Communication between sponsoring agencies, administration, volunteers, and center members assures that all are in agreement with regard to direction and plans. • Governing documents should reflect clarity of vision in simple, easy-to-understand language and must be reviewed regularly.
Administration and Human Resources	• A senior center shall have clear administrative and human resources policies and procedures that contribute to the effective management of its operation. It shall be staffed by qualified personnel–paid and volunteer–capable of implementing its program. • Clear job descriptions allow staff and volunteers to understand job expectations and boundaries. • Training and educational opportunities allow staff and volunteers to experience personal growth, and to develop professional skills needed to carry out the goals, objectives, and philosophy of the center.
Program planning	• A senior center shall provide a broad range of group and individual activities and services that respond to the needs and interests of older adults, families, and caregivers in its community or service area. • Many questions need to be answered before implementing programs to make certain that programs are relevant: Who is the population to be served? What changes have taken

	place in the demographics of my community to which we need to respond? What are the trends in our field that hold true across geographic regions? What programs are dying, what interests are emerging? • Examine the suggestions and needs expressed by the participants and other stakeholders, such as family members, staff, volunteers, businesses, and community agencies. • Consider what strategies are feasible and what the priorities are. What resources are available or can be garnered to address the needs? • Today's seniors span several generations, creating a wide range of physical, cognitive, cultural, and geographical aspects to consider. Program implementation may involve not only planning programs at your center but in a variety of settings to reach different audiences. • Activities and services shall promote personal growth and respond to individual differences. • Outreach and marketing are integral parts of your programming.
Evaluation	• A senior center shall have appropriate and adequate arrangements to evaluate and report on its operation and program. The evaluation may be used to measure accomplishments or to uncover program or operational problems. • It may be an overall assessment of the center's operation or an examination of one aspect of its program. • Evaluations can be quantitative (number of people served, service units provided) or qualitative (the impact of the program on the people it serves). • The senior center's administrator and its governing

	structure are responsible for ensuring evaluations are done on a regular basis, that appropriate individuals are involved, and that a report is prepared with information from the evaluation.
Fiscal management	• A senior center shall practice sound fiscal planning and management, financial record keeping, and reporting.
Records and Reports	• A senior center shall keep complete records required to operate, plan, and review its program. • It shall regularly prepare and circulate reports to inform its governing structure, its participants, staff, funders, public officials, and the general public about all aspects of its operation and program. • All records are to be reviewed regularly by designated staff for evaluation and continued appropriateness. Because of the content of these records and reports, it is imperative that they are kept confidential.
Facility	• A senior center shall make use of facilities that promote effective program operation and that provide for the health, safety, and comfort of participants, staff, and community. • The Self-Assessment Committee will look at the location and accessibility of the center and at its design, equipment, and furnishings. A very important aspect of a senior center is the safety of the building.

CAPRA Standards:

Agency Authority, Role, and Responsibility	• Source of Authority • Mission • Agency goals and objectives • Vision • Administrative policies and procedures • Agency relationship
Planning	• Involvement in local planning • Planning with regional, state, and federal agencies • Park and recreation system master plan • Strategic plan • Community involvement
Organization and Administration	• Organizational structure • Internal communication • Public information policy and procedure • Management information systems
Human resources	• Personnel policies and procedures manual • Code of ethics • Equal opportunity employment and workforce diversity • Background investigation • Staff qualification • Job analyses for job descriptions • Chief administrator
Financial management	• Fiscal policy • Comprehensive revenue policy • Fiscal management procedures • Purchasing procedures • Accounting system • Independent audit • Annual biennial budget
Programs and services management	• Recreation programming plan • Program objectives • Outreach to diverse underserved populations
Facility and land use management	• Maintenance and operations management standards
Public safety, law enforcement, and security	• Codes, laws and ordinances • Authority to enforce laws by law enforcement officers • General security plan
Risk management	• Risk management plan and procedures
Evaluation, assessment, and research	• Systematic evaluation processes

North Carolina Standards:

Administration	• Governing body • Program policies • Program goals • Enrollment policies and procedures • Discharge policies • Medication policies • Participant's rights description • Grievance policies and procedures for families • Advance directives policy • Non-discrimination policies • Confidentiality policies • Elder abuse or neglect reporting policies • Geographic area served • Inclement weather policies • Transportation policies • Hours and days of operation • Types of services provided • Personnel policies • Insurance
Personnel	• General requirements • Staffing pattern • Program director • Day care homes: only staff is operator • Health care coordinator of adult day health centers • Staff responsible for personal care in adult day health centers • Volunteers
The facility	• General requirements • Additional facility requirements for adult day health • Day care of day health programs in multi-use facilities • Building construction • Equipment and furnishings
Program operation	• Planning program activities • Enrollment procedures • Planning services for individual participants • Program activities • Health and personal care services • Nutrition • Transportation • Emergencies and first aid • Plan for emergencies • Evacuation plan

	• Medications • Program evaluation
Records	• Individual client records • Program records for day care and day health centers and homes

Senior Center Operations and Program Evaluation:

Services, Publicity, and Marketing	• Information and referral/case assistance • Services • Publicity for the center and its services and activities • Marketing to special populations and the community
Activities, volunteer opportunities, advocacy, and transportation	• Activities • Opportunities for volunteers • Advocacy • Transportation to the center
Planning, evaluation, and input from older adults	• Governance • Input from older adults • Planning
Staff	• General personnel practices • Individual training and professional development planning
Other operational issues	•
The Extra Mile	•

CARF Standards:

Compliance obligations	• Legal • Regulatory • Confidentiality • Reporting • Licensing • Contractual • Debt covenants • Corporate status • Rights of the persons served • Privacy of the persons served • Employment practices • Mandatory employee testing
Privacy	• Confidential administrative records • The records of the persons served • Security of all records • Confidentiality of records • Compliance with applicable laws concerning records • Time frames for documentation in the records of the persons served
Participating provider's financial planning and management activities	Are designed to meet: • Established outcomes for the persons served • Organizational performance objectives • Include • Preparation of an annual budget • Fiscal policies and procedures, including internal control practices • Evidence of an annual review or audit of the financial statements of the participating provider conducted by an independent accountant authorized by the appropriate authority
Financial management	If the participating provider takes responsibility for the funds of persons served, it implements written procedures that define: • How the persons served will give informed consent for the expenditure of funds • How the persons served will access the records of their funds

	• How funds will be segregated for accounting purposes • Safeguards in place to ensure that funds are used for the designated and appropriate purposes • How interest will be credited to the accounts of the persons served, unless the organization Is subject to guidelines that prohibit interest-bearing accounts • How monthly account reconciliation is provided to the persons served
Healthy and safe environment	
Documented competency-based personnel training	Both: • Upon hire • Annually In the following areas: • Healthy and safety practices • Identification of usage environment factors • Emergency procedures • Evaluation procedures, if appropriate • Identification of critical incidents • Reporting of critical incidents • Medication management, if appropriate • Reducing physical risks
Emergency procedures	For: • Fires • Bomb threats • Natural disasters • Utility failures • Medical emergencies • Violent or other threatening situations That satisfy: • The requirements of applicable authorities • Practices appropriate for the locale That address, as follows: • When evacuation is appropriate • Complete evacuation from the physical facility • When sheltering in place is appropriate • The safety of all persons involved • Accounting for all persons involved • Temporary shelter, when applicable

	• Identification of essential series • Continuation of essential services • Emergency phone numbers • Notification of the appropriate emergency authorities
Unannounced emergency procedures testing	Are conducted at least annually: • On each shift • At each location • Include complete actual or simulated physical evacuation drills • Are analyzed for performance that addresses: • Areas needing improvement • Actions to be taken • Results of performance improvement plans • Necessary education and training of personnel • Are evidenced in writing, including the analysis
Evacuation routes	• Accessible Understandable to: • Persons served • Personnel • Other stakeholders, including visitors

Safety access	• First aid expertise
	• First aid equipment and supplies
	• Relevant emergency information on the
	  • Persons served
	  • Personnel

Critical incidents	• Prevention • Reporting • Documentation • Remedial action • Timely debriefings conducted following critical incidents The following critical incidents, if applicable: • Medication errors • Use of seclusion • Use of restraint • Incidents involving injury • Communicable disease • Infection control • Aggression or violence

	• Use and unauthorized possession of weapons • Wandering • Elopement • Vehicular accidents • Biohazardous accidents • Unauthorized use and possession of legal or illegal substances • Abuse • Neglect • Suicide or attempted suicide • Sexual assault • Other sentinel events
Risk management	• At least annually That addresses: • Causes • Trends • Actions for improvement • Results of performance improvement plans • Necessary education and training of personnel • Prevention of recurrence • Internal reporting requirements • External reporting requirements

Standard or universal precautions	For:
	• Infection prevention
	• Infection control
	That include:
	• Training regarding
	  • Infections
	  • Communicable diseases
	  • Appropriate use of standard or universal precautions
	Guidelines for addressing these procedures with:
	• Persons served
	• Personnel
	• Other stakeholders

Safe transportation	• Appropriate licensing of all drivers • Regular review of driving records of all drivers • Insurance covering • Vehicles • Passengers

	• Safety features in vehicles • Safety equipment • Accessibility • Training of drivers regarding • The organizations transportation procedures • The unique needs of the persons served • Written emergency procedures available in the vehicles • Communication devices available in the vehicles • Maintenance of vehicles owned or operated by the organization according to manufacturer's recommendations • If serves are contracted, an annual review of the contract against elements above of this standard

Comprehensive health and safety inspections	Are conducted:
	• At least annually
	• By a qualified external authority
	• Result in written report that identifies
	  • The areas inspected
	  • Recommendations for areas needing improvement
	  • Actions taken to respond to the recommendations

Comprehensive health and safety self-inspections	• Are conducted at least semi-annually on each shift
	• Result in a written report that identifies
	  • The areas inspected
	  • Recommendations for areas needing improvement
	  • Actions taken to respond to the recommendations

Primary source verification	Verification of:
	• Backgrounds of personnel in the following areas, if required:
	  • Criminal checks
	  • Immunizations
	  • Fingerprinting
	  • Drug testing
	• The credential of all applicable personnel (including licensure, certification, and registration):
	  • With primary sources

	• When applicable, in all states/provinces or other jurisdictions where personnel will deliver services • Time frames for verification of backgrounds and credentials, including: • Prior to the delivery of services to the persons served or to the organization • Throughout employment • Actions to be taken in response to the information received concerning: • Background issues • Credentials verification
Documented personnel training	At: • Orientation • Regular intervals That addresses the identified competencies needed by personnel
Performance management	Job descriptions that are: • Reviewed annually • Updated as needed Performance evaluations for all personnel directly employed by the participating provider that are based on: • Job functions • Identified competencies • Reviews of all contract personnel utilized by the participating provider
Provision of services by personnel that are consistent with relevant external or internal requirements and education	• Legislation governing practices • Licensure requirements • Registration requirements • Certification requirements • Professional degrees • Professional training to maintain established competency levels • On-the-job training requirements • Professional standards of practice
Communication of rights of the persons served	Communicated to the persons served: • In a way that is understandable • Prior to the beginning of service delivery or at initiation of service deliver

	• Annually for persons served in a program for longer than one year Available at all time for: • Review • Clarification
System of rights that nurtures and protects the dignity and respect of the persons served	• Confidentiality of information • Privacy Freedom from: • Abuse • Financial or other exploitation • Retaliation • Humiliation • Neglect Access to: • Information pertinent to the person served in sufficient time to facilitate his or her decision making • Their own records Informed consent or refusal or expression of choice regarding: • Service delivery • Release of information • Concurrent services • Composition of the service delivery team • Involvement in research projects, if applicable Access or referral to: • Legal entities for appropriate representation • Self-help support services • Advocacy support services • Adherence to research guidelines and ethics when persons served are involved, if applicable • Investigation and resolution of alleged infringement of rights • Other legal rights All information is transmitted in a manner that is clear and understandable.
Clear protocols	Implements a policy and written procedure by which persons served may formally complain to the provider that specifies:

	• That the action will not result in retaliation or barriers to services • How efforts will be made to resolve the complaint • Levels of review, which include availability of external review Time frames that: • Are adequate for prompt consideration • Result in timely decisions for the person served • Procedures for written notification regarding the actions to be taken to address the complaint • The rights of each party • The availability of advocated or other assistance • Makes complaint procedures and, if applicable, forms • Readily available to the persons served • Understandable to the persons served • Documents formal complaints received
Accessibility needs (physical, cognitive, sensory, emotional, or developmental)	Assesses the accessibility needs of the: • Persons served • Personnel • Other stakeholders Implements an ongoing process for identification of barriers in the following areas: • Architecture • Environment • Attitudes • Finances • Employment • Communication • Technology • Transportation Community integration, when appropriate Any other barrier identified by the: • Persons served • Personnel • Other stakeholders

BCRPA Older Adult Performance Standards

Aging process	• The older adult leader will be able to demonstrate their knowledge of the physiological, psychological and sociological effects of aging and its relationship to physical activity. • The older adult leader will have knowledge of common healthy challenges facing older adults and how these changes affect functional mobility and independence.
Leadership and communication skills	• The older adult leader will conduct a safe and effective exercise program using a variety of leadership styles and communication techniques appropriate for older adults.
Exercise analysis and Risk management	• The older adult leader will demonstrate an understanding of methods that ensure safe and effective exercise programming for older adults.
Program planning	• The older adult leader will design an effective program using established methods and training principles. The older adult leader will be capable of evaluating programs using measurable outcomes to ensure effective and appropriate programming.
Program organizing skills	• The older adult leader will design and conduct a safe and effective older adult exercise program using a variety of formats. The older adult leader will have the ability to adapt programming to meet the needs of participants using available resources. • The older adult leader will demonstrate knowledge of Canada's Food Guide & recommended supplements in the guide.
Use of music	• The older adult leader will demonstrate an understanding of the reasons for using music (or not) in an older adult exercise program.
Ongoing personal professional development and marketing strategies	• The older adult leader will demonstrate an understanding of their scope of practice and how to pursue continuing education related to fitness leadership in the older adult field. The older adult leader will develop strategies for marketing their older adult programs.

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