The Journey to ACEing Seniors Care at OSMH

End Falls this Fall Conference
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Orillia Soldiers’ Memorial Hospital

- We are 108 years new!
- 1,275 staff; 176 credentialed staff; 292 Volunteers
- 230 bed capacity (approx. 175 operating)
- 5 state-of-the-art operating theatres
- 54,276 ER Visits
- 8,454 Inpatient Visits
- 908 Babies born
- Governed by a 21-member, volunteer Board of Directors
North Simcoe Muskoka LHIN

Total Population: 475,676
Rural Population: 140,523
Land Area: 8,455 Sq Km
Total Senior Population: 86,097
Five acute care hospitals
The Silver Tsunami is Here

10,000 American Baby Boomers will turn 65 years old every day until 2031

If you can’t stop the wave…

Learn to SURF!

## Older Adults are Susceptible to Geriatric Syndromes

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<th>Geriatric Syndrome</th>
<th>Increased Risk for Adverse Outcomes</th>
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<td>Frailty/Functional Decline</td>
<td>Caregiver Stress</td>
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*Geriatric Syndromes = Increased Risk for Adverse Outcomes*
Hazards of Hospitalization

- Hostile environment
- Depersonalization
- Bed rest / immobility
- Malnutrition / dehydration
- Cognitive Dysfunction
- Medicines / Poly-pharmacy
- Procedures
5 Common Complications for Hospitalized Older Adults

- Delirium (25 – 30%)
- Functional Decline (31%)
- Urinary Dysfunction (15%)
- Serious Adverse Drug Events (5%)
- Falls with possible fractures (3.6 per 1000 pt days)

“Acute Care for Elders – A Model for interdisciplinary care, Malone, Capezuti, Palmer, eds.” 2014
Cost of Functional Decline & other complications associated with hospitalization

- Prolonged lengths of hospital stay (LOS)
- Increased risk of returning to hospital
- A greater risk of Institutionalization
- Higher mortality rate
We Must Think Outside the Box!!
Comparing its baseline performance year of 2009/10 to 2013/14, four years after the launch of the ACE Strategy, Mount Sinai achieved significant results for its medical inpatients aged 65 and over, including:

- reduced total lengths of stay (12 days → 8 days)
- reduced alternate level of care days (20 percent reduction)
- reduced readmissions within 30 days (15 percent → 13 percent)
- reduced urinary catheter use (56 percent → 15 percent)
- reduced pressure ulcer incidence (93 percent reduction)
- improved rate of returning patients home as opposed to other institutional settings (71 percent → 79 percent)
- increasing rates of patient satisfaction (95 percent → 97 percent)
ACE Collaborative Journey

- The Canadian Foundation for Healthcare Improvement, in partnership with Canadian Frailty Network, today announced the 18 organizations that will improve healthcare for older adults by adapting Mount Sinai Hospital’s (Toronto) proven Acute Care for Elders (ACE) Strategy in their healthcare facilities.

- The ACE Collaborative is based on the Mount Sinai ACE Strategy led by Dr. Samir Sinha, director of geriatrics for the Sinai Health System and a respected clinician and researcher. Seventeen healthcare organizations from Ontario, Quebec, New Brunswick, Nova Scotia and Yukon have been selected, along with an international team based in Iceland.

- Orillia Soldiers Memorial was selected to be a participant in the collaborative.
ACE Collaborative Journey

- The CFHI–Canadian Frailty Network partnership is providing each Canadian team with funding of up to $40,000, as well as online learning tools, educational webinars and coaching from experts in elder care and quality improvement. The initiative will support the teams to become experts in healthcare practices that benefit older patients in the communities where they reside.

- Mount Sinai Hospital’s ACE Strategy is a seamless model of care for older adults, spanning the patient care continuum from the emergency department to inpatient, ambulatory and community care settings. Geriatricians, psychiatrists and other physicians as well as nurses, social workers, therapists, pharmacists and dieticians work together to provide coordinated care for older patients. With its ACE Strategy, Mount Sinai has generated sustained results for patients over age 65, including reducing total lengths of stay by 28 percent, lowering readmission rates by 14 percent, and saving the health system $6.7 million in avoidable costs in 2014.
Multi Year Initiative

Provincial SFH Strategy Released

2011 - Management Restructuring - SFH Care Program established

2012 - Paint, lighting, staff badges adjusted to meet Code Plus specs

11/2012 - Planning for Modified HELP program on S2

16/9/2012 - Seniors Visioning Day - Community Collaboration

7/2013 - 5 P Purposeful Rounding on S2

4/2014 - Adopt ACE Philosophy of Care

4/2014 - OSHM SFH Operations Committee established

9/2014 - Wall clocks in patient rooms

9/2015 - Corporate Role Out Delirium Standard of Care

9/2016 - Submission to ACE QI Collaborative

The story continues

2011

12/2010 - SMH endorsed commitment to enhance geriatric care as OSHM priority

3/2011 - SFH Steering Committee established

6/2012 - 600 Steps program on S2

11/2012 - OSHM Seniors Vision Statement: "Inspiring Outstanding Care for Healthier Aging"

2013

6/2013 - PDSA Delirium Standard of Care, CAM and toolkit on S2 begins

7/2014 - Participant in SFH Task Force

5/2015 - Participate as SFH ACTION Team Member

2014

Family Presence policy

2015

29/2/16 - Acceptance to ACE QI Collaborative MOU Signed

2016

Hospital Soldiers' Memorial Orillia
What is an ACE Unit?

- An inpatient medical unit
- Focused on providing comprehensive care of older patients, 65 years and above
- Care provided by a specialized interprofessional team
- Care focused on:
  - treating patient’s acute medical illness
  - maintaining their independence by promoting self care
  - prevent the loss of physical and cognitive abilities
- Care on the ACE Unit will be driven by these few key principles:
  - Patient and Family-Centred Care
  - Interprofessional Collaboration
  - Comprehensive Discharge Planning
  - Prepared Environment
**Aim Statement:** We will continue to transform the delivery of care for our geriatric patients by redesigning or establishing new approaches based on the principles of the Mount Sinai Ace Strategy and implement them in a sustainable manor.

**Description of the initiative:** Evaluate, reinforce and sustain previously implemented components of the ACE Strategy and implement new approaches so to achieve a comprehensive, effective and sustainable ACE Unit.
Establish a comprehensive ACE Unit by adapting Mt. Sinai Medical Unit Organizational Structure

**AIM**

**Outcome Measures**
- Establish comprehensive ACE Unit by March 31, 2017
- 75% of ACE Unit staff receive ACE Unit specific education (ACE standard of Care) by Jan 1, 2017
- 100% of staff who have completed ACE Unit education will receive OSMH ACE Specialist credential by March 31, 2017

**Primary**
- Establish current state of existing OSMH senior friendly practices
- Adapt and Trial relevant Mt. Sinai ACE Unit processes
- Establish core competencies and related education requirements for employment on ACE Unit
- Increase team commitment and pride in Senior Care

**Secondary**
- Conduct Lean Current State Mapping exercise
- Conduct Lean future state mapping exercise
- Research and adapt Mt. Sinai ACE Unit competencies
- Research viability of providing staff access to NICHE education modules
- Establish designated OSMH “ACE specialist” credential for staff who have completed ACE Unit education requirements
**AIM**

*Improve patient outcomes as measured by a decrease in the incidence of delirium*

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**Primary**

**Recognize delirium and manage it when it occurs**

*Provide all unit staff with delirium education*

*All patients* screened using CAM tool

*High risk patients have a specific plan of care for prevention and management*

**Responsive behaviour Standard of Care implemented in patient who meet criteria.**

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**Secondary**

*Engage patients and families as integral team members in the recognition and prevention of delirium*

*All patients’ families receive education on delirium*

*All new admits and families receive 1:1 orientation including what to expect on the ACE Unit*

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**Outcome Measures**

*Improve patient outcomes as measured by a 10% decrease in the incidence of delirium by March 31, 2017*

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**Change Ideas**

- Review & update current delirium Standard of Care, toolkit, CAM tool
- Review/update e-learning education modules
- “Unit Huddle” talks
- Post progress to education targets on unit board
- Inter-rater reliability testing
- Provide interactive education using skits/scenarios
- Track and post CAM tool compliance results
- Track and post % of positive CAMs that result in a specific plan of care
- Work with OSMH/NSM LHIN responsive behaviour lead re: development, education and communication of related SOC.
- Track and post % of eligible patients with evidence of responsive behaviour interventions
- Create standardized admission package for ACE Unit.
- Formalize responsibility for delivery of education packages and unit welcome & orientation interviews.

*patients > 65 years of age who are admitted to the ACE Unit*
**AIM**

ACE Unit patients will return to pre-admission destination

**Outcome Measures**
- 80% of ACE Unit patients will return to pre-admission destination by March 31, 2017
- 75% ACE Unit specific interdisciplinary staff will receive MOVE-ON education (e-learning modules)
- 50% of eligible patients will participate in 3 mobilization activities/day by Jan 31, 2017

**Primary**

Reduce incidence of Functional Decline

**Secondary**

Fully implement MOVE-ON program on the ACE Unit by March 31, 2017

Engage patients/families as integral team members in the recognition and prevention of functional decline

All new admits and families receive 1:1 orientation including what to expect on the ACE Unit.

All eligible patients and families receive education on the MOVE ON Program

**Change Ideas**

- Review/Modify MOVE ON education for e-learning portal
- Provide 1:1 MOVE ON implementation support
- Provide ACE Unit specific interdisciplinary staff MOVE-ON education (e-learning modules)
- Post progress to education targets on unit board
- Create standardized admission package for ACE Unit
- Formalize responsibility for the delivery of education packages and unit welcome and orientation interviews
Measurements

- Falls with Harm per 1000 patient days
- 30 Day readmission rate
- Average LOS
- % ALC days
- Return to preadmission destination
- % Would recommend this hospital to your family and friends
- % During hospital stay obtained all the information you needed about your condition and treatment
- % ACE pts with documented 3 mobility activities / day
- % ACE patients with completed CAM within 24h of admission and daily
- Incidence of delirium in patients admitted to ACE unit
- Patient Satisfaction
- Staff Satisfaction
Wish List and Next Steps

- Implement a High-Risk Screening Tool for the Identification of seniors who would most benefit from admission to ACE
- Introduce GEM nurse to provide additional supports to high risk older patients
- Become NICHE (Nurses Improving Care for Health System Elders) hospital so to access their resources to educate frontline professionals in geriatric care and benchmark our performance.
- Spread ACE processes of care across the organization
Thank you!