



Health System Improvement Guide

# ACUTE CARE FOR THE ELDERLY



Executive summary	4
Introduction	6
The problem	7
The aim	8
Specific objectives	8
The measures	9
Baseline data for acute medical patients 85 years or over	9
Outcome measures	9
Balancing measures	9
The drivers of change	10
ACE patient case study	11
The change package: Overview	12
The change package: Preadmission to the ward	13
Referral and admission criteria	13
Weekend and on-call roster	14
The JAM Tool	14
The change package: Care during inpatient stay	16
Ward set-up, practices and processes	16
ACE Admission Planner	18
ACE Care Plan	18
Staffing model—nursing	19

Staffing model—allied health	22
The change package: Care during inpatient stay/Timely and safe discharge or transfer	24
ACE Huddle	24
The change package: Timely and safe discharge or transfer	26
Changes to electronic discharge summary	26
The outcomes	27
Old versus new models of care	27
Number of ACE cases	28
ACE length of stay	28
ACE plus AT&R combined length of stay	29
Readmissions	29
Level of care	30
A nurse’s story	31
The future direction	32
The collaborative team	33
References	34
Appendix A: JAM Tool	35
Appendix B: ACE Admission Planner	36
Appendix C: ACE Care Planner	40
Appendix D: Position description—Clinical nurse specialist, gerontology	42
Appendix E: ACE Huddle	46
Appendix F: Electronic Discharge Summary	49
Appendix G: ACE poster	

“The right patient, the right place, the right time....” are words that are often heard in health care. During the winters of 2012 and 2013, acute geriatric patients were not in the ‘right place’ within Middlemore Hospital. This vulnerable patient group was spread across general medical services with no coordinated approach to care.

The Acute Care for the Elderly (ACE) model was established in 13 of the 26 beds in Ward 5 in May 2013. Its aim was to improve care for complex elderly patients aged 85 and over by creating a multidisciplinary acute geriatric unit to coordinate acute care with rehabilitation services. The specific objectives of the project were to:

- » decrease the ACE to Assessment, Treatment & Rehabilitation Unit (AT&R) average length of stay (LOS) from 25 to 20 days
- » decrease the ACE average LOS from 8.6 to 7 days
- » decrease the readmission rate from 6% to 4%
- » decrease the institutionalisation rate from 14% to 8%.

The changes made from the traditional model of care were to have the patient managed under the care of a geriatrician, provide early intensive multidisciplinary input to prevent functional decline, provide acute care and rehabilitative care within the same ward, eliminate a transition of care and to better coordinate the multidisciplinary team input to return the patient home.

By the end of 2014, the ACE project had achieved its objectives in reducing the ACE to AT&R average LOS and the rate of institutionalisation. It had also made substantial reductions in the average acute LOS and the readmission rate (Table 1, p. 5).

ACE benefits patients. Patients are more likely to return to their own homes, and less likely to be readmitted to hospital within seven days. The ACE team prioritise family meetings for all patients to help family members support

patients at home after discharge. The early rehabilitation intervention stops functional decline for the patients, helping to avoid hospital admissions.

There are also benefits for the healthcare provider, Counties Manukau Health (CM Health). ACE saves CM Health \$698,500 per year in bed days and funding for residential and private hospital care by reducing the average length of stay, the rate of readmission, and the number of patients who need institutionalised care. Taking into account the additional investment of \$389,490 per year for staffing under the ACE model of care, the net projected annual savings are \$309,010 per year (Table 1, p. 5).



Table 1: ACE project outcomes

Measure	Baseline	End of 2014	Savings	Cost savings per year
Acute plus AT&R LOS	25 days	17 days	600 bed days (approx.)	\$690 per bed day x 600 = \$414,000
Re-admission rate	6%	4.3%	10 readmissions = 50 bed days (approx.)	\$690 per bed day x 50 = \$34,500
Acute LOS	8.6 days	7.6 days		
Rate of institutionalisation	14%	6%		\$250,000
			<b>Total gross cost savings</b>	<b>\$698,500</b>
			<b>Additional staffing costs</b>	<b>\$389,490</b>
			<b>Total net cost savings</b>	<b>\$309,010</b>

Acute Care for the Elderly (ACE) is a collaborative project to create a coordinated, multidisciplinary care pathway for acute care of the frail elderly.

The ACE model of care was established in 13 of the 26 beds in Ward 5 of the Assessment, Treatment and Rehabilitation Unit (AT&R) at Middlemore Hospital in May 2013. Middlemore Hospital is the largest healthcare facility under Counties Manukau Health (CM Health), which is the district health board that serves the South Auckland and Franklin areas of New Zealand's North Island. The ACE unit admits approximately 50 patients per month, 600 patients per year.

ACE was developed, funded and implemented as part of Beyond 20,000 Days. This was an umbrella campaign run by Counties Manukau Health that supported a range of projects aimed at keeping people well in their communities. The campaign used the Breakthrough Series (BTS) approach to train and support participating teams in improvement methodology and collaborative working.<sup>1</sup> The BTS was structured as four learning sessions interspersed with action periods. During action periods, project teams in Beyond 20,000 Days used Model for Improvement methodology to develop 'packages' of change ideas which related to the overall campaign aim.<sup>2</sup>

The ACE project team comprised nurses, allied health staff and service managers on Ward 5 who were supported by an expert group of consultants and senior managers. A project manager and improvement advisor were added to the team through Beyond 20,000 Days to assist with the planning and implementation of the project.

The model of care the ACE team developed is based on comprehensive geriatric assessment (CGA). CGA is a "multidimensional interdisciplinary diagnostic process focused on determining a frail elderly person's medical, psychological and functional capability in order to develop a

coordinated and integrated plan for treatment and long term follow up".<sup>3</sup> Comprehensive geriatric assessment has proven efficacy in improving outcomes for elderly patients and keeping them out of institutional care after discharge.<sup>3</sup> A Cochrane review published in 2011 concluded that the benefit of CGA wards is adequate to justify reorganisation of services to provide this model.<sup>3</sup> It does not appear to result in increased cost to hospitals and, from a societal standpoint, appears to result in potential cost reductions.<sup>3</sup>

This guide describes the development and implementation of the CGA-based model of care created by the ACE team.



Team members at work during a Beyond 20,000 Days learning session

Before ACE was initiated, the patient mix on Ward 5 included acute adult general medical patients of all ages who were being managed as outliers under General Medicine, as well as elderly rehabilitation patients. The mix of acute general medical patients of all ages with elderly rehabilitation patients on Ward 5 did not work well. Two incompatible models of care were in play: acute medical and AT&R. The ward, part of the AT&R Unit, was not set up to care for general medical patients. The systems and processes used for the acute patients were adopted from AT&R processes and were time-consuming in this population group. The urgent demands of acute patients reduced the time staff had available to work with the rehabilitation patients. As a result, acute medical patients were not receiving the highest quality of care, and rehabilitation patients did not get adequate staff time for optimum rehabilitation care.

The staffing model on the ward was not designed for acute services, and the staffing skill set was inadequate to manage acute medical patients. Due to the inappropriate skill mix and time pressures on staff there were patient safety issues at night. During the winter of 2012 there was a high incident rate with development of pressure injuries and falls being a particular problem.

In addition to the problems in Ward 5, there were vulnerable frail elderly acute medical patients in need of rehabilitation input spread across Middlemore Hospital's general medical wards. The hospital lacked a coordinated care pathway, which resulted in some of these patients receiving care that focussed on their short-term, acute conditions rather than providing the support they needed to maintain long-term wellness after discharge.

Geriatric patients also recover from acute episodes more slowly than younger adults and often have a high number of associated comorbidities. Those who are transferred to rehabilitation following acute care often still have ongoing care needs relating to their acute episode.

Prior to ACE, the majority of patients who had an acute episode were not reviewed by a geriatrician unless they went to rehabilitation. There was also an additional transition of care within the hospital (a physical discharge from the medical service and then admission to rehabilitation service), which took an average of two days, consumed significant clinical time, and delayed progress for the patient while the new team assessed and planned their care. An audit undertaken of the time spent by the entire clinical team to discharge a patient from General Medicine and admit under AT&R showed that the total time taken by all disciplines was 14.5 hours per patient. Finally, the situation created communication problems for staff, with AT&R nurses having to liaise with up to 10 different medical teams after transfer of a patient to their service.



The aim of the ACE project was to create a multidisciplinary acute geriatric unit to coordinate acute care with rehabilitation services in Ward 5. The unit would:

- » manage acutely unwell, non-specialised frail elderly patients 85 years of age or over
- » exclude specialised patients with acute stroke, respiratory and cardiac conditions
- » admit patients directly to Ward 5 from Emergency Care (EC) or the community, rather than from acute medical wards
- » involve a full multidisciplinary team (MDT) earlier in the patient's stay to reduce deterioration in the acute phase, start earlier discharge planning, improve linkages to inpatient rehab services in AT&R and coordinate the patient's ongoing care with community services.

### Specific objectives

- » Decrease the ACE to AT&R average length of stay (LOS) from 25 to 20 days.
- » Decrease the ACE average LOS from 8.6 to 7 days.
- » Decrease the readmission rate from 6% to 4%.
- » Decrease the institutionalisation rate from 14% to 8%.



Team members at work during a Beyond 20,000 Days learning session

## Baseline data\* for acute medical patients 85 years or over

- » Between 70 and 110 patients per month fall within our target population every year.
- » Average LOS in acute medicine is five days. The seven-day readmission rate is 6%.
- » The rate of institutionalisation to a rest home or private hospital is 14% – approximately 145 patients per year.
- » Ninety patients per year (90%) transfer to AT&R for rehabilitation. On average, this group stay twice as long in acute care and have an average LOS of 25 days in total across acute and rehabilitation services.

## Outcome measures

- » ACE to AT&R LOS
- » ACE LOS
- » Readmission rate
- » Institutionalisation rate

## Balancing measures

- » Six month mortality

- » Comparison with General Medicine LOS
- » Comparison with AT&R LOS

\* Baseline data is from May 2013.



# THE DRIVERS OF CHANGE

AIM

PRIMARY DRIVERS

SECONDARY DRIVERS

TERTIARY DRIVERS

CHANGE CONCEPTS

CHANGE IDEAS

We aim to improve the care for >85 acute medical patients by implementing an Acute Care for the Elderly model. We aim to decrease the ACE/AT&R length of stay from 25 to 20 days, ACE length of stay from 8.5 to 7 days, readmission from 6% to 4%, and institutionalisation rate from 14% to 8% for all the patients that admitted under the ACE criteria in Middlemore Hospital by July 2014.

Preadmission to ward

Care during inpatient stay

Timely and safe discharge/transfer

Identification for ACE

Resource availability

Admission

Clinical practice

Documentation

Communication

Acute stage rehab

Family engagement

Allied health interventions

Patient info

Timeliness

Communications

Discharge planning

Interventions in place

Documentation

Screening

Alert system

Communication

Assessment criteria

Bed availability

Bed allocation

Triage

Assessment & screening

Variation in clinical practice- investigation

Use pull system

Develop operational definition

Match the amount to need

•Match resources

•Document control

•Owner engagement

Standardisation

Give people access to information

Education

Standardisation

Standardisation

Document control

Tool to identify high need individuals

Someone from our team screening

Needs identification screening tool

Education for Emergency Care

Alert for over 85 year old patients

Develop referral criteria

Develop referral criteria

Demand-based bed management in Ward 5

Clear 24/7 pathway

Bed management

Full MDT screening

Develop admission planner

Integrated care plan

9 am MDT huddle

Doctor at morning meeting

Identification of ACE patients on board

Nursing education with acute medicine

Identification from admission screening

Weekend physiotherapy

Identification of patient to AT&R in MDT

Barriers to discharge in huddle

Patient/whaanau survey on discharge

Goal discharge date

Mrs G is a 94 year old woman who lives with her husband in a retirement village. She cares for her husband, who has dementia and has declined services in the past. While she is keen to be as independent as possible, she is becoming very fatigued, unwell and worried about their situation.

Mrs G was admitted to ACE with non-ST segment elevation myocardial infarction (NSTEMI), a possible lower respiratory infection (LTRI) and congestive heart failure (CHF). Mrs G was admitted on a Wednesday and wanted to go home on Friday so she could look after her husband. She was very fatigued. The plan on admission was for the acute illness to be managed with antibiotics and diuresis. A goal discharge date (GDD) was set in consultation with the multidisciplinary team, Mrs G and her family.

A full MDT screen was completed within the first 24 hours and Mrs G received MDT management (Table 2).

Table 2: Mrs G's MDT management

MDT Screen	Plan
Clinical Nurse Specialist	Discusses with Mrs G rationale of accepting assistance in the home to maintain independence for as long as possible.
Pharmacist	Medication review - no medication changes apart from an added course of antibiotics
Dietician	BMI 26 – appetite good – malnutrition risk low
Physiotherapist	Mobility screened and safe to mobilise with walking stick. Mrs G at baseline regarding mobility, but suffering fatigue due to current illness.
Occupational Therapist	<ul style="list-style-type: none"> <li>• Fatigue management</li> <li>• Education on energy conservation</li> <li>• Issued short term shower stool with arms</li> <li>• Advised to take regular rests</li> </ul>

<b>NASC (Needs Assessment and Service Coordination)</b>	Started a support package including - <ul style="list-style-type: none"> <li>• 3 hours personal cares for fatigue management</li> <li>• 1.5 hours household management</li> <li>• Meals on wheels</li> </ul>
<b>Social Worker</b>	<ul style="list-style-type: none"> <li>• Mrs G has a son and daughter who live nearby and can visit on average three times a week to lend a hand to chores and cooking.</li> <li>• Information given to Mrs G and family regarding residential facilities and advice to consider this when it may be needed.</li> <li>• Information regarding Enduring Power of Attorney given to family.</li> </ul>

A family meeting was organised to update Mrs G's family on her health status. Family members were given a care package to help manage Mrs G's fatigue and advised how to use it. The family were happy to try the care package at home, but were also given information about residential care facilities. Needs Assessment and Service Coordination (NASC) set up appropriate support.

Mrs G was discharged on her GDD with two weeks of oral antibiotics. The support for household management and hot meals was put in place along with equipment for fatigue management.

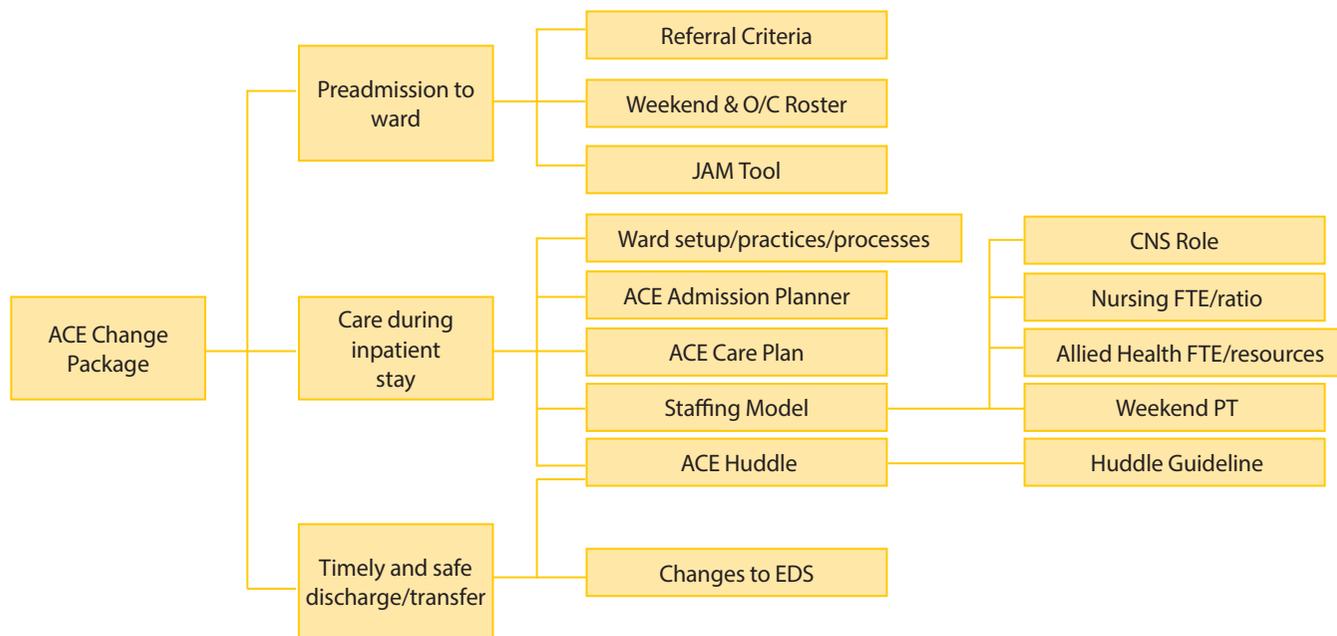
The design of the ACE model of care focussed on three primary drivers:

1. Preadmission to the ward
2. Care during the inpatient stay
3. Timely and safe discharge or transfer

In order to set up the ACE Unit, ward and operational processes, staffing models and admission criteria and processes were initially modelled on existing practice within the AT&R Unit. Once the unit was up and running, change ideas were tested and further refined using PDSA cycles.

The change package comprised new processes and tools that supported the primary drivers (Figure 1).

Figure 1: The ACE change package



The first driver focussed on identifying the patients who would most benefit from the ACE model of care and developing efficient referral and admission processes to get them into the right place at the right time.

## Referral and admission criteria

Entry criteria for the ACE Unit are:

- » Age 85 or over with
- » an acute medical illness (e.g. infection with delirium or electrolyte disturbance) and/or
- » complex medical conditions including co-morbidity, frailty, immobility, multiple medications and psychosocial problems and/or
- » geriatric syndrome such as immobility, frailty, incontinence, dementia, disability and falls.

Exclusion criteria are:

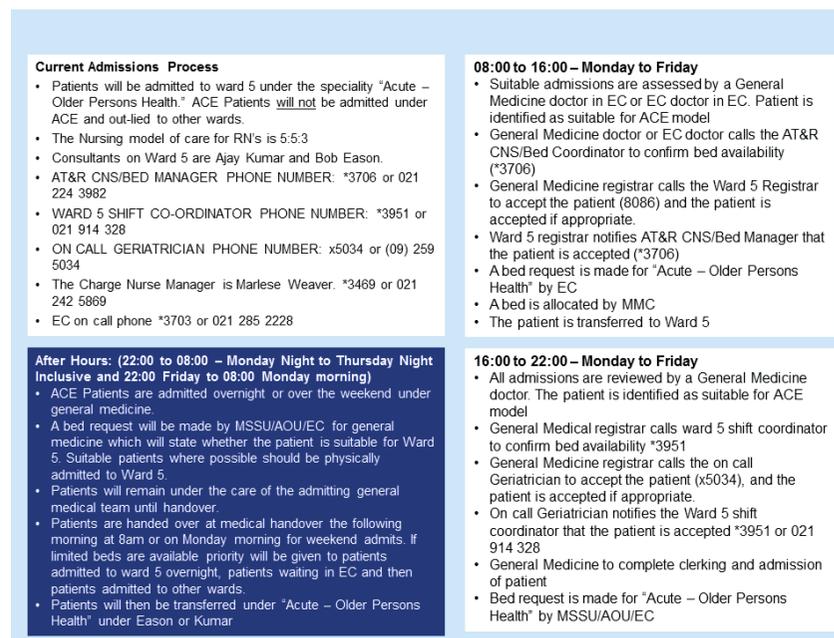
- » Acute stroke
- » Acute myocardial event
- » Acute respiratory conditions—severe pneumonia or exacerbation of chronic obstructive pulmonary disease
- » Patients who require specialised monitoring
- » Patients who require care in the High Dependency Unit or Intensive Care Unit

- » Patients who require acute orthopaedic or surgical intervention

Although research suggests it is not advisable to set age criteria for comprehensive geriatric assessment models,<sup>3</sup> ACE used a selection criterion of 85 years or over to manage capacity. Patients under 85 years were occasionally admitted if they met other selection criteria.

Referral and admission processes were put in place for weekdays between 8am and 4pm, weekdays between 4pm and 10pm, and after hours (Figure 2). The information is available to staff via the ACE page on the CM Health intranet.

Figure 2: ACE referral and admission process



### Weekend and on call roster

A roster defines who the on-call geriatrician is for weekend and after hours consultations to support the admission process from EC.

### The JAM Tool

The JAM Tool (named after Judith and Mike, two members of the team) was developed to select patients who would benefit most from ACE. The tool identifies patients who will require admission to AT&R after acute care, or who are at risk of needing institutionalised care. It can be used as either an inclusion or an exclusion tool for ACE.

The JAM Tool (Appendix A) calculates an overall score for each patient based on their current actual (not premorbid) scores across six risk criteria:

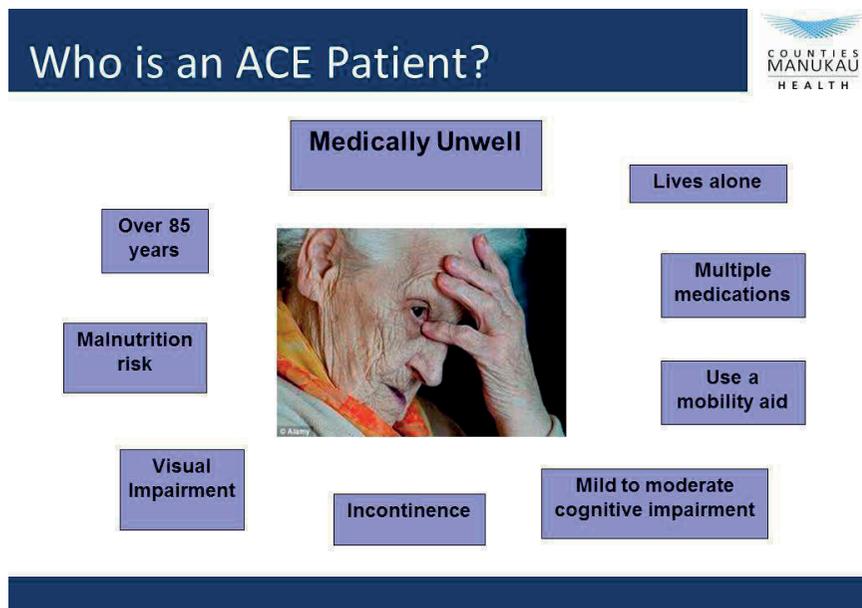
- » Family support
- » Mobility
- » Cognition
- » Continence
- » Vision
- » Malnutrition

The JAM Tool was created from expert opinion within the ACE working group, including a senior physiotherapist, a clinical nurse specialist for gerontology, a charge nurse manager, an occupational therapist, a dietician and others. The criteria measured by the JAM Tool correlate well with the Mayo Clinic Admission Tool.<sup>4</sup> The criteria and scoring system were tested with ACE patients.

The ACE team originally intended that the JAM Tool would be used to screen patients in EC. Potential referrals were to be discussed with a gerontology consultant, accepted and transferred to the ACE team on the ward in one smooth process. However, it rapidly became apparent that this referral system would have to be refined. The uptake of the JAM Tool among EC staff was low, and the on-call gerontology consultant was not always part of the ACE team, leading to communication and bed management problems. In an effort to improve the uptake, AT&R registrars promoted use of the JAM Tool and provided education to medical registrars. This has improved the uptake, but it needs to be done regularly because the registrars rotate.

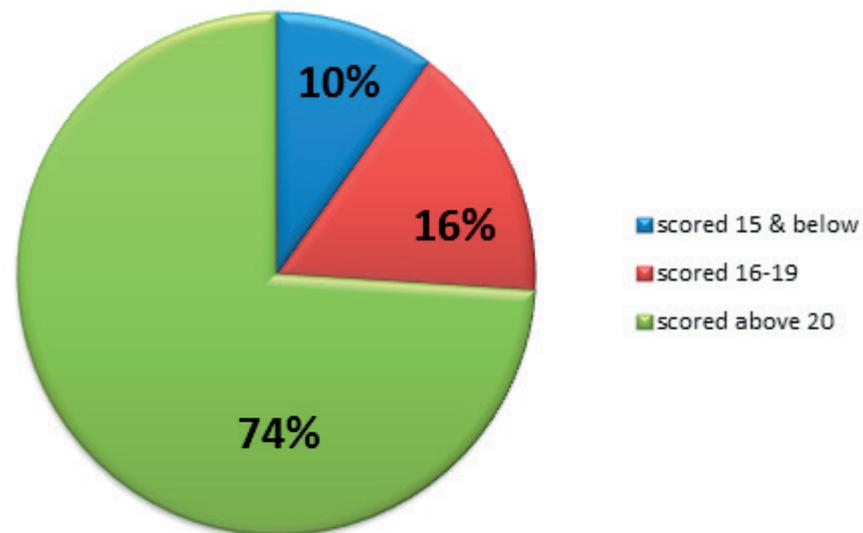
Developing this tool refined the ACE team's understanding of which patients will benefit most from referral to ACE. As ACE is currently limited to 13 beds, developing this understanding is important to optimise the value of the ACE model.

Figure 3: Who is an ACE patient?



The JAM Tool has good inter-rater reliability and can predict those at risk of needing institutionalised care (Figure 4).

Figure 4: JAM scores on admission for patients who went on to institutionalised care



There were a number of challenges ACE needed to address to deliver high quality care during the inpatient stay.

Firstly, the ward set-up, practices and processes needed to support effective delivery of the ACE model of care.

Secondly, the existing uncoordinated approach to patient assessment by the multidisciplinary team in Ward 5 needed to be improved. There was not one central point within the notes for the assessments carried out by the MDT. Each discipline had a different document for their initial assessment/screen. Patients were repeatedly asked the same questions, leading to a lot of time wasted and frustration by patients, staff and family/whaanau. There are a number of patient safety assessments that must be completed within 6 to 24 hours of admission. These were done separately, without one point of entry.

Thirdly, with the increased acuity in the patients' conditions it became evident that a care plan based on patient goals did not address the nursing interventions required when treating acutely unwell patients. With the reduced length of stay, ACE staff needed a care plan that could be accessed easily, and which would make patients' current nursing needs evident in a timely manner.

Fourthly, the Ward 5 staffing model had to be aligned with the needs of the new ACE Unit. Ward 5 was set up as a 26-bed rehabilitation ward, and the model of nursing was based on stable rehabilitation patients. Under ACE, there would be admissions after hours and an increase in the number of patients being admitted and discharged per day. In addition, there was limited time to educate nursing staff on acute medical interventions and delirium, and a limited number of senior nurses with acute medical assessment skills.



### Ward set-up, practices and processes

#### Ward meetings

Ward 5 has two gerontology teams with 13 patients each. Each team has a consultant, registrar and house officer. The consultant attends ward rounds twice a week. The registrar and house officer attend a daily ward round, a "huddle" on Mondays, Wednesdays and Fridays, and a full MDT meeting once a week.

There are two MDT meetings in a week – one for each gerontology team. The full medical team, physiotherapist, occupational therapist, dietician, social worker, pharmacist, needs assessor, clinical psychologist, other interested specialities and nursing attend the meetings. At the MDT meeting, the patients' progress and plans are discussed. It is also where family meetings are planned and goal discharge dates are set.

ACE huddles (see p. 24 and Appendix E) are held three times a week to update progress and plans, and to ensure that goal discharge dates and complex discharge planning are on track. The medical registrar or house officer, physiotherapist, occupational therapist, social worker and nursing staff attend the huddles.



### Daily ward routine

An email is sent to each team member every morning with an update on the planned daily activities for the ward: admissions, family meetings and anticipated discharges.

The charge nurse manager or associate charge nurse manager liaises with the clinical nurse specialist for gerontology (CNSG) and the medical registrar to assess the availability of beds. The registrar and the CNSG attend the medical handover to identify patients suitable for the ACE model of care. They then review the patients accepted in the medical handover and organise their transfer to Ward 5.

Transferred patients are welcomed to the ward. Nursing staff assess each patient within six hours for fall, delirium and pressure injury risk. The physiotherapist, occupational therapist and social worker assess the patient using the ACE admission planner (see p. 18 and Appendix B) within 24 hours. A dietetic assistant screens all patients within 24 hours of admission and an oral health screen is also completed within the first 48 hours. The admission planner is completed by the MDT team. Plans of care are also completed.

### Family meetings

Patients are reviewed at the ACE huddle and MDT meeting. At that time, staff discuss whether a family meeting is required. This is decided with the consent of the patient or the person holding enduring power of attorney. Decisions for family meetings are usually based on the need for discussion around rehabilitation goals, a patient's deteriorating condition, change in level of care or at the request of the family and/or patient.

Family meetings are usually arranged for Wednesday or Thursday mornings, depending on the family's availability. If those days are unsuitable, staff try to arrange an alternative.

At the meeting, staff update family members about the patient's progress and offer support for discharge planning. The patient and family are encouraged to raise any concerns they may have. NASC, Primary Options for Acute Care (POAC) or Accident Compensation Corporation (ACC) referral will be done if needed. Family members are given a copy of the family meeting minutes.

### Upon discharge

The electronic discharge summary (EDS) has an allocated space for multidisciplinary input to provide information on assessment, interventions, progress and recommendations for each patient (see p. 26 and Appendix F).

The time of discharge and transport home are organised a day before the discharge date. If the family are unable to provide transport before 11am, patients are transferred to the discharge lounge to accommodate admissions.

### ACE Admission Planner

A key feature of the comprehensive geriatric assessment model for older adults is coordinated multidisciplinary assessment.

The ACE team developed an admission planner that provides a coordinated multidisciplinary approach to assessment and establishes one document to capture all multidisciplinary assessments/screens on admission for all ACE patients (Appendix B). Development of the admission planner started with an existing document from Bay of Plenty DHB. The team also reviewed the admission planners used on medical and surgical wards within CM Health, and held a number of brainstorming sessions with all members of the multidisciplinary team.

Patients are screened by the multidisciplinary team on admission, as opposed to on referral. This allows staff to establish a care plan early that contributes to a reduction in length of stay and supports early transition to self-care and independence.

The admission planner reflects a patient and family-centred approach. It provides the platform for establishing an efficient partnership between staff and patients and their families. It allows for quick identification of patients'

needs and any potential barriers to discharge. It is structured to facilitate a coordinated multidisciplinary approach that helps to build rapport and incorporates cultural aspects into care.

An audit of completion rates showed that 90 per cent of patients were fully screened by the multidisciplinary team within 24 hours. The information captured in this tool informs the patient's nursing and allied health care plan.

ACE is ready to adopt the planner, but a complete an audit of the content is still needed. The admission planner is also being tested for use with AT&R patients.

### ACE Care Plan

A written care plan promotes continuity of nursing care and sharing of important information about the patient with all MDT members.

Multidisciplinary care planning and written care plans are widely recognised to contribute to effective patient care. Individualised care plans can improve care processes by reducing ad hoc decision making during a patient's hospital stay.<sup>5</sup> Gjorup et al. argue that all acutely admitted medical patients should have a care plan made.<sup>6</sup>

The ACE team developed and trialled an eight-day care planner that could be completed each shift (Appendix C). This also functioned as a visual reminder after eight days to investigate whether the patient needed to be considered for a rehabilitation period.

The team had originally envisaged a multidisciplinary care plan, but this idea succumbed to the complexities of trying to combine numerous specialised care plans. Instead, the morning ACE huddle was incorporated into the nursing care plan to improve communication and ensure that nursing staff were consistently

kept abreast of the allied professionals involved in a patient's care.

The ACE care plan is used in conjunction with the admission planner and other patient safety screening assessments for falls, pressure injuries and delirium, according to CM Health policy. It is prepopulated with the patient safety risk assessments and a further five spaces can be completed with specific interventions related to the patient's care.

Although the care plan is primarily completed by nursing staff, allied health staff can add interventions. The care plan can be used in the ACE huddle to inform the multidisciplinary team of progress from a nursing perspective and of any new interventions.

The care plan is placed in the same folder as the medication chart to be accessible to nursing staff throughout the shift.

Feedback from nursing staff suggests that the new format is easier to find and complete, and ensures that specific nursing interventions are updated and attended to.

Whilst the new format has been tested, the content captured and the benefits to the wider team have not yet been audited. Senior nursing staff on the ward are currently auditing the content of the care plans and will form a working group to collate the information gathered for use in the ongoing testing of the care plan.



### Staffing model—nursing

Ward 5 forecast up to 50 acute admissions per month under ACE, in addition to rehabilitation admissions. The ACE team researched acute medical ward staffing models for registered nurses in the two months prior to the beginning of the ACE project.

Making ACE work required three extra nurses on Ward 5: two additional registered nurses (RN) and a clinical nurse specialist for gerontology (CNSG) (Table 3).

The reasons for the increase in registered nurses were:

- » to administer interventions for acutely unwell patients
- » to provide skilled assessment and monitoring of acute conditions to cover 24-hour admissions
- » to accommodate the increase in patient turnover.

One of the registered nurses providing cover on any shift could be an enrolled nurse.

Table 3: Changes to the nursing staffing model

Shift	Pre-ACE		ACE	
	RN	HCA	RN	HCA
AM Shift	5 RN	2 HCA	5 RN	2 HCA
PM Shift	4 RN	2 HCA	5 RN	1 HCA
Night Shift	2 RN	1 HCA	3 RN	1 HCA

RN – Registered Nurse  
HCA – Health Care Assistant

\* Staffing for a mixed 26 bed ward – 13 beds ACE; 13 beds Rehabilitation

The role of the CNSG includes assessing ACE patients prior to admission, ensuring a coordinated treatment and discharge plan and supporting the nurses on the floor with unstable patients (Appendix D).



Judith Gavin, CNS for Gerontology

## Education

As well as changing the staffing model, the ACE team implemented an intensive nursing education programme. The programme was based on up-skilling in the four main diagnosed reason groups (DRG) in the elderly: respiratory conditions, congestive heart failure, urosepsis and delirium. The team also ensured that staff had cannulation competencies. In addition, they implemented the Confusion Assessment Method to manage delirium. Sessions tailored to the scope of practice of health care assistants were also provided.

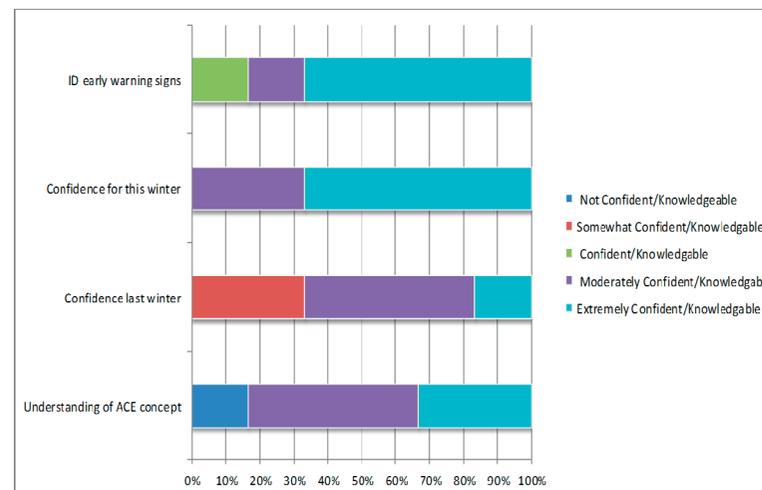
Figure 5: Upskilling—what did we need?



Nursing staff were asked to self-assess their understanding of the ACE model of care, their ability to identify early warning signs and their level of confidence in caring for acute medical patients before (last winter—2012) and after (this winter—2013) the nursing education programme.

The results show that the nursing staff gained confidence in caring for acute patients, with those who felt extremely confident increasing from 17% to 67%. All nurses reported that they were able to confidently identify early warning signs and 83% were moderately to extremely confident in their knowledge of the ACE model of care (Figure 6).

Figure 6: Nurses' knowledge and confidence before and after the education programme



### Staffing model—allied health

Making the ACE model of care work required changes to the allied health staffing model and the roles of allied health staff (Table 4, p. 23).

All patients admitted to ACE are assessed jointly by a physiotherapist and an occupational therapist, using a joint safety screen form. Evaluation includes:

- » a review of the patient's home environment
- » previous function verses current function
- » activities of daily living
- » bed mobility transfers mobility
- » respiratory status (if required)
- » musculoskeletal or neurological examination (as clinically indicated)
- » equipment provision (as clinically indicated).

Patients may be discharged if they are managing well at their baseline, or have further therapy as required for safe discharge. Referrals to community services occur as required.

The main difference from a medical ward is that all admissions to the ward are assessed by therapists, rather than those who meet certain criteria or are referred by another health professional. Because there is no need for transfer to a new ward, rehabilitation can begin as soon as practical, if required. Rehabilitation assistants deliver therapy delegated by the physiotherapist, occupational therapist or dietician, under supervision. Speech language therapists are available by referral (no full-time specialist was required to cover this service).

There is one NASC needs assessor allocated to work on Ward 5. This assessor covers both AT&R and ACE patients. The needs assessor assesses patients identified as requiring NASC input by written referral from a member of the ward team. The needs assessor's role is to identify the patients' support needs and goals through an interRAI assessment and coordinate services required prior to discharge.

Ideally, the needs assessment is completed at a point during the inpatient stay when the potential clinical outcome has been defined but there is still time to complete service coordination so that home-based support services or transfer to an age-related residential care facility can be organised upon discharge.

Table 4: Changes to the allied health staffing model and roles

Discipline	Pre-ACE FTE	Post-ACE FTE	Additional to role under ACE model of care
<b>Physiotherapy</b>	2.5	2.5	<ul style="list-style-type: none"> <li>Safety screen completed on all patients within 24 hours</li> <li>Full assessment within 48 hours</li> <li>Rehabilitation is commenced asap</li> <li>Weekend PT coverage</li> </ul>
<b>Occupational Therapy</b>	2.5	2.5	<ul style="list-style-type: none"> <li>Safety screen completed on all patients within 24 hours</li> <li>Full assessment within 48 hours</li> <li>Rehabilitation is commenced asap</li> </ul>
<b>Rehabilitation Assistant</b>	2.5	1.5	<ul style="list-style-type: none"> <li>Dietetic e-Nutrition screening on all patients</li> <li>Oral health screening on all patients</li> </ul>
<b>Social Work</b>	1.0	1.6	<ul style="list-style-type: none"> <li>Screen completed on all patients within 24 hours of admission to identify social issues including elder abuse/neglect</li> </ul>
<b>Dietician</b>	0.75	0.8	<ul style="list-style-type: none"> <li>Following RA Dietetic e-Nutrition Screen, the Dietitian assesses all high malnutrition risk patients and some moderate/low risk patients based on clinical judgement</li> <li>ACE requires quicker cycle of assessment, diagnosis, intervention, monitoring and discharge planning.</li> <li>Contribution to EDS</li> </ul>
<b>Speech Language Therapist</b>	0.2	0.2	<ul style="list-style-type: none"> <li>Referral only</li> </ul>

\* Staffing for a mixed 26 bed ward – 13 beds ACE; 13 beds Rehabilitation

## Staffing model—medical

A key difference under the ACE model of care is that the patients who were previously managed under the care of a general medical physician are now managed under the care of a geriatrician.

Ward 5 has 26 beds with an average mix of 13 ACE patients and 13 elderly rehabilitation patients. The 26 beds are managed by two medical teams. Each team takes an even mix of the ACE and rehabilitation patients.

Each medical team consists of a geriatrician (0.6 FTE), a full-time registrar and a full-time house officer. At the initiation point of the pilot there was only one registrar shared between the two medical teams. This placed a lot of strain not only on the registrar but also on the geriatricians and the house officers. After the initial 12 months, a second registrar was added to the ward to provide one registrar per medical team. This enabled a much more appropriate level of cover.

The geriatricians do formal ward rounds twice per week with their team and call on patients as required on other days. The geriatricians also attend complex family meetings as required.

There is geriatrician cover on site in the weekend to review sick patients and those identified as requiring planned review over the weekend. Due to the limited availability of medical cover, ACE patients are not admitted under the ACE medical team over the weekend.

## ACE Huddle

The ACE Huddle supported two of the primary drivers: care during the inpatient stay, and timely and safe discharge or transfer.

The ACE team developed the huddle to address a number of problems:

- » There was no established goal discharge date (GDD) to work towards.
- » Initially staff had difficulty determining/measuring patients' status with regard to their medical conditions.
- » Not having assigned NASC personnel available caused delays in discharge while waiting for supports to be arranged.
- » It was difficult to have the medical team on board during the process of discharge planning due to their limited availability.
- » Staff were unable to establish an appropriate and realistic GDD without medical input.
- » It was not always clear what each discipline had planned for assessment, intervention and discharge planning, which made it difficult to identify reasons for delays in discharges.
- » Unexpected discharges without notice from the medical team were occurring. The transfer process for ACE patients to AT&R was unclear.

The change idea was to form a multidisciplinary huddle to establish GDD and identify barriers to discharge on a daily basis. The huddle would encourage more involvement from the medical team, and provide a means of identifying ACE patients who were ready for transfer to AT&R. The ACE team also wanted

to create a document that would capture the discussion of each patient's progress towards discharge during the huddle.



The ACE Huddle in action

Every organisation can benefit from implementing The Organisational Huddle Process. The costs associated with this initiative are minimal and there are tremendous benefits. Unlike many communication and team-building programs that are on-time events that often return marginal long-term results, this process by its very nature promotes communication, collaboration, focus, speed and results. Participants develop an enhanced appreciation for face-to-face communication, accountability, trust support and mutual respect. Like the best football teams, participants learn to discuss game plan, make quick adjustments to changing condition and support each other toward the accomplishment of a common goal.<sup>7</sup>

The team started developing the ACE Huddle in December 2013. They began by developing and testing a form to guide discussion in the huddle and identify barriers to discharge (Appendix E). Meeting times and days and the length of the huddle were also tested. A facilitator was appointed to encourage all members to contribute specific information. Medical attendance at the huddle was still unsatisfactory. At this stage the ACE huddle happened daily.

The form was successful, but it needed to be supported by a guideline to formalise the aims, roles and responsibilities, and to define the process (Appendix E). Daily meetings were unsuccessful, as there was little new information to provide on patients' progress. The team tested reducing the frequency of the huddles to Mondays, Wednesdays and Fridays. The reduced frequency did not cause delays to patient discharges.

The ACE team tried holding the huddle at different times to improve attendance by medical staff. The best time was between 11:30am and 12pm, following ward rounds. Nursing staff facilitate the huddle.

The ACE Huddle has become a good forum for MDT communication, including the medical team. GDDs have been established, and barriers to discharge identified. The huddle plays an important role in discharge planning and achieving the goal ACE LOS. It is running smoothly and has become part of the ward routine.

The huddle took two months to establish, but since then the ACE length of stay has reduced to an average of 7.6 days across 2014. This has remained very stable, indicating consistent application of care delivery. The huddle has been one of the most influential changes ACE implemented.

Effective interaction with stakeholder groups, brainstorming, teamwork and time management were instrumental in making the huddle work. It was also important to set processes down in written form for clarity.



The ACE Huddle in action

### Changes to electronic discharge summary

The elderly are more likely than younger people to have an established general practitioner (GP).<sup>3</sup> It is important to maintain a link for communication of long-term care plans with GPs, as well as with patients, families and other healthcare facilities and therapists. This communication facilitates sustained long-term wellness after discharge.

In some cases, the medical team's focus is exclusively on the treatment of patients' acute conditions.<sup>8</sup> This is reflected in the medical discharge summary, which does not reliably communicate the long-term care plan after discharge. The medical electronic discharge summary (EDS) template did not provide an opportunity for nursing and allied health staff to give feedback and provide a care plan to the patient, family, GP and other healthcare facilities. In addition, information from the family meeting could not be communicated via an electronic form.

The ACE team reviewed the suitability of the more comprehensive established AT&R discharge summary (Appendix F) for use with ACE patients. This discharge summary provided a good structure to capture the handover of information from the medical team, pharmacy, nurses and allied health. It also captured any important details from the family meeting. The AT&R discharge summary was adopted for use in every-day practice.

The AT&R discharge summary enables easy access for the GP and other healthcare professionals and therapists, and helps to establish a smoother continuum of care to support the patient, family and healthcare facilities on discharge.

The ACE model of care is now well established as part of the General Medicine and Adult Rehabilitation & Health of Older People (ARHOP) divisions of CM Health. The evidence presented in this section shows positive outcomes across all measures. Length of stay measures in particular show continuing improvement. Comparison to the baseline has proved challenging across the course of the project as the ACE team progressively focuses more on patients with complex geriatric needs who are at greater risk of a change in level of care, introducing some bias as more complex patients are selectively admitted to the ACE unit.

The ACE unit is part of the wider hospital system and, as such, is influenced by events and processes that operate within the hospital. These can have an impact on outcomes. Every effort was made to collect outcome measures at a level that would clearly demonstrate the impact of the changes made within the ACE unit. Improvements have been sustained for a sufficient period to be confident that outcomes will continue to reflect current trends.

## Old versus new models of care

Figures 7 and 8 show key differences in the model of care prior to the introduction of ACE and under the ACE model.

Figure 7: Features of the old model of care prior to ACE

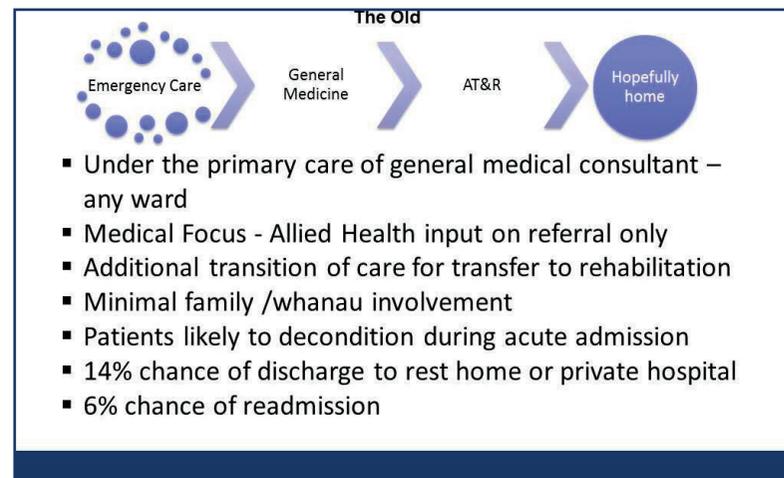
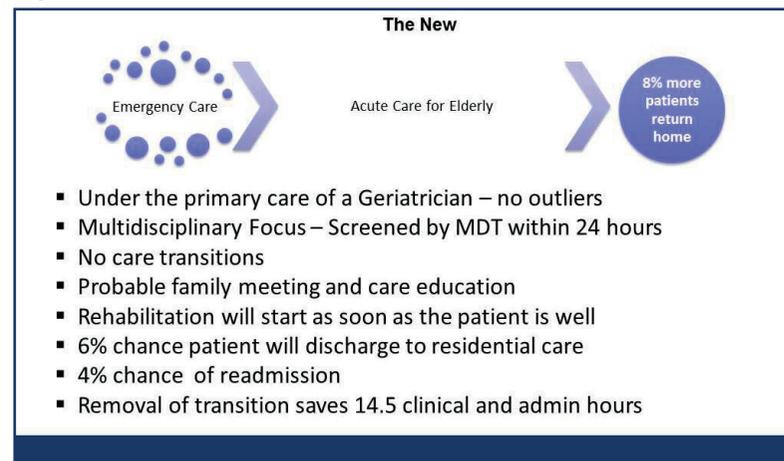


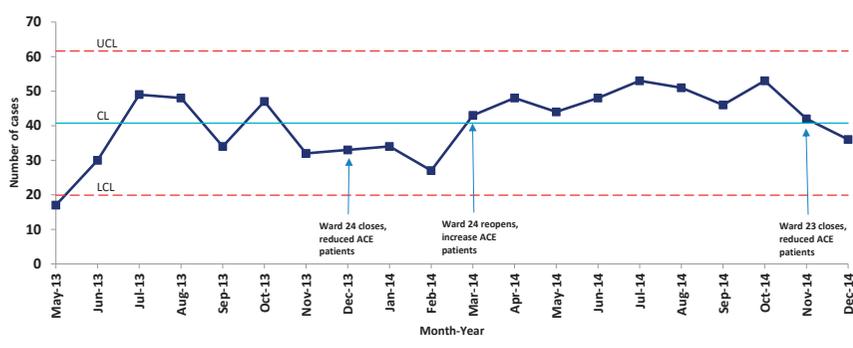
Figure 8: Features of the new model of care under ACE



## Number of ACE cases

Over 860 patients have been treated under the ACE model. The number of patients treated each month reduced due to ward closures for refurbishments in Adult Health & Rehabilitation of Older People (ARHOP) Wards 23 and 24 between December 2013 and March 2014, and again from November 2014. Excluding the closure periods, the ACE unit admitted nearly 50 patients per month in 2014 (Figure 9).

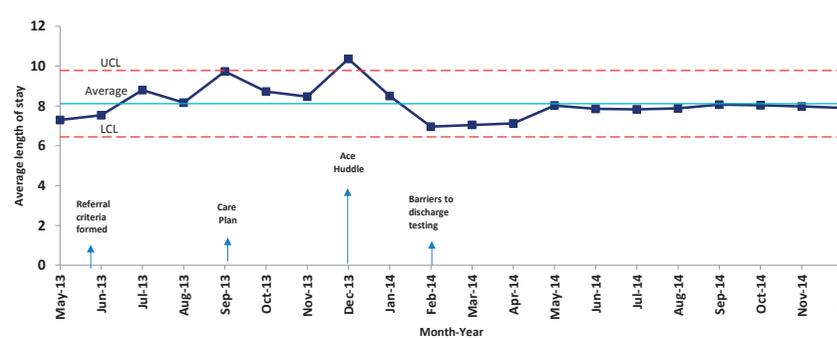
Figure 9: ACE patients admitted per month since opening in May 2013



## ACE length of stay

Average LOS in the first four months of ACE was 8.6 days. The ACE team aimed to reduce this to seven days. The average LOS was variable over the first eight months as the model of care was established. Since the development of the ACE Huddle in the two months from December 2013, LOS has reduced to a stable average of 7.6 days (Figure 10). This indicates consistency in the delivery of care. The target of a seven-day average LOS is achievable with more focus on seven-day care delivery.

Figure 10: ACE length of stay since May 2013

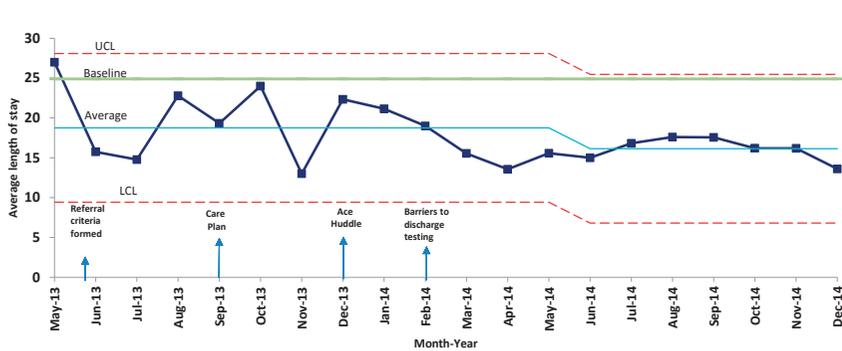


## ACE plus AT&R combined length of stay

Prior to the introduction of ACE, one in every 11 medical patients over the age of 85 transferred to the AT&R wards for rehabilitation following their acute episode. The average LOS for this cohort of patients was 25 days (10 days in acute care and 15 days in rehabilitation). ACE aimed to reduce the average LOS for this group from 25 to 20 days by eliminating the transfer of care between teams and starting early rehabilitation to reduce functional decline. Under the ACE model, patients who require ongoing rehabilitation following resolution of an acute episode will nominally transfer to AT&R but will remain under the care of the same ACE team within Ward 5.

With the exception of the first month, the average combined ACE to AT&R LOS has been lower than the baseline under the ACE model. It continues to decline (Figure 11). In 2014, the average LOS for the 74 patients who came through the ACE pathway was 17 days (6.5 days under ACE and 10.5 days under AT&R). This equates to an estimated saving of 600 bed days.

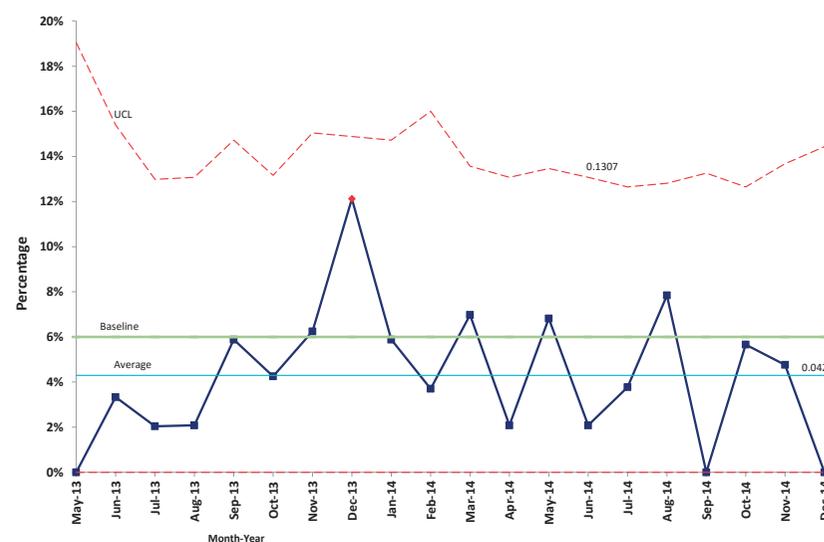
Figure 11: Average length of stay for ACE patients who remain under AT&R for rehabilitation



## Readmissions

Prior to the introduction of ACE, the baseline seven-day readmission rate for medical patients 85 years or over was 6%. ACE aimed to reduce this to 4%. Figure 12 shows that the readmission rate for the ACE unit is 4.3%, although from a statistical perspective the change is not considered significant. If the readmission rate remains at this level, the ACE model will prevent one readmission for every 60 patients treated. This extrapolates to approximately 10 readmissions per year, saving approximately 50 bed days.

Figure 12: Readmission rate within seven days of discharge from ACE

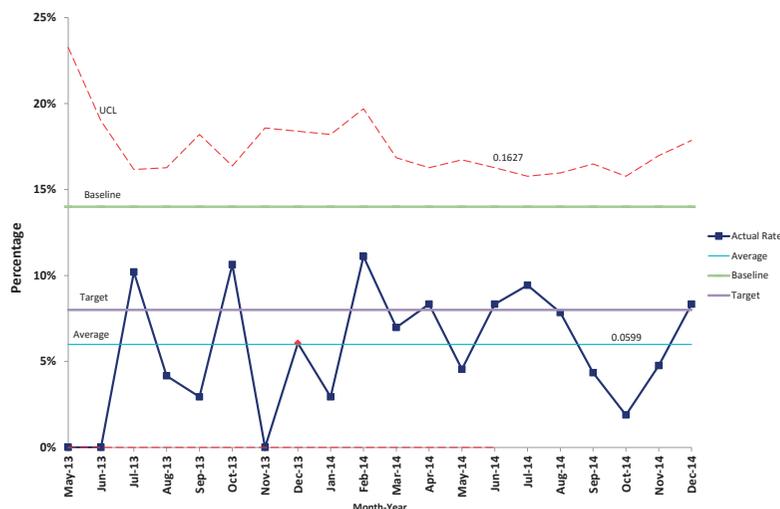


The bed days saved by the reduction in LOS combined with the reduction in readmissions add up to substantial financial savings for CM Health. At a cost per bed day of \$690, the combined savings from 650 fewer bed days extrapolate to \$448,500.

## Level of care

There is strong evidence that ACE-type models of care reduce institutionalisation at a rate of one person for every 13 treated.<sup>3</sup> Prior to the introduction of ACE, the baseline rate of institutionalisation at CM Health for patients aged 85 years or over was 14%. Since ACE was introduced, the rate of institutionalisation has averaged 6%, a significant improvement from the baseline (Figure 13).

Figure 13: Rate of change to a more dependent level of care resulting in institutionalisation



The improvement means that patients are able to remain in their own homes for longer, which in most cases is the patient's preferred outcome. From a financial perspective, reducing admissions to rest homes or private hospitals saves money both for patients, who contribute pension income and possibly more depending on their financial position, and for CM Health, which contributes to rest home and private hospital costs.

Economic analysis of the financial savings for CM Health from the reduction in the institutionalisation rate is difficult for a number of reasons. Firstly, the baseline rate of institutionalisation is possibly overstated by patients admitting from residential care but being recorded as an admission from home. Secondly, the contribution that CM Health makes for each patient admitted to residential or private hospital care is extremely variable, ranging between \$0 and \$1300 per week.

To estimate potential savings, we made the following conservative assumptions:

- » ACE shows an eight per cent reduction in the rate of institutionalisation for 600 patients treated per year.
- » The avoided admission to rest home or private hospital is only for three months.
- » The monthly cost saving to CM Health is \$1739 or (\$400 per week).

Under this scenario, annual savings for CM Health are \$250,000 per year.

Mr A is an 85 year old man with a history of prostate cancer with metastases to his bones. He was admitted to Ward 5 as a medical outlier under the medical team during the weekend with a lower respiratory tract infection and a haemoglobin level of 65 (the normal level is 130–170 g/L<sup>3</sup>). He received two units of red blood cells on Saturday and a further two on Sunday.

On Monday, we offered to take him under ACE, but the medical team were discharging him that day. As he was on the ward, I went and visited him. He had been given his prescription and was discharged, but as I chatted to him I found out that he was feeling exhausted and was worried that he would not be able to work in his garden, which he missed.

Mr A understood that his low haemoglobin was due to the metastases in his bones, but this was his second transfusion which only lasted 90 days. He had been advised to see his GP to check his haemoglobin in eight weeks instead of 12 weeks. I talked about him accepting some home help with hygiene cares to preserve his energy for things he enjoyed, like his garden. Mr A accepted the offer of help.

I asked him about his bone disease and talked about pain management. He reported taking his long acting morphine and sometimes needing short acting too. I asked him about his bowels and I got the impression that he was possibly under-medicating his pain to avoid constipation (a common side effect of morphine).

Through my interview I learned that he was known to a hospice but had not been visited for months because he had reported to them that he was fine. I discussed further care that the hospice nurses would be able to assist with, especially with his bowel and pain management and to help cope with his fatigue. He consented for me to contact the hospice to update them on his condition and request a personal visit.

After Mr A left the ward for the Discharge Lounge, I talked to the occupational therapist about the possibility of providing some support to assist Mr A with showering. Although he was capable of showering without help, support would enable him to conserve his energy. The occupational therapist arranged with the hospice nurse for an occupational therapy assessment to take place in the community.

I reflected on the care Mr A received under the acute medicine model compared to what he would have received under the ACE model (Table 5).

This comparison is in no way intended to criticise the care given under the acute medicine model. Instead it highlights how the ACE model can further enhance patient care and communication between services.

Table 5: Acute medicine vs. ACE model comparison of care

Acute Medicine	ACE Model
<ul style="list-style-type: none"> <li>• Corrected low haemoglobin</li> <li>• Discharged home into care of GP</li> <li>• Discussion was had after discharge in regards to Hospice and OT referral</li> </ul>	<ul style="list-style-type: none"> <li>• Corrected low haemoglobin</li> <li>• OT, PT and SW screening</li> <li>• Palliative referral as Mr A was symptomatic of his metastatic disease</li> <li>• Family meeting arranged to update family about change in health status and future</li> <li>• Personal cares services initiated</li> <li>• Hospice referral</li> </ul>

The evidence and outcomes for the pilot phase of the ACE project demonstrate good clinical outcomes for the patient and good financial and operational outcomes for CM Health. The ACE model of care was well supported by evidence from research literature, and the project demonstrated that the positive outcomes achieved internationally could be replicated at CM Health.

The future direction needs to look at ways of overcoming some of the financial and operational constraints that currently limit CM Health's ability to extend this model of care.

The ACE team will continue to focus on ways of better identifying patients who are likely to have rehabilitation needs following the acute phase of their admission. By selectively admitting more of this patient group, ACE can focus on those patients who are likely to benefit most. Being able to target patients in this way also maximises the bed day savings that can be made in this complex group.

Capital & Coast District Health Board has recently developed a similar model for complex elderly patients managed in two full wards. This initiative has experienced similar outcomes to those under the ACE model.

A key lesson from this project was in the institution of the ACE huddle. This drove better coordination of care and ensured that patients received the interventions they required in a timely manner. Following implementation of the huddle, the length of stay per patient dropped by a full day, and variation in the length of stay was greatly reduced. This approach to care coordination should be considered for spread within the hospital.



## THE COLLABORATIVE TEAM

<p><b>Geoff Green</b> (Clinical Lead) Clinical Head AT&amp;R</p>	<p><b>Ian Dodson</b> Service Manager Allied Health &amp; Geriatrics</p>	<p><b>Lyn Cooper</b> Clinical Nurse Director ARHOP</p>	<p><b>Marlese Weaver</b> Clinical Nurse Manager Ward 5</p>
<p><b>Judith Gavin</b> Clinical Nurse Specialist Gerontology</p>	<p><b>Leigh Haldane</b> Physiotherapy &amp; OT Section Head ARHOP</p>	<p><b>Michael McCallin</b> Physiotherapy AT&amp;R</p>	<p><b>Joanna O'Leary</b> Physiotherapy AT&amp;R</p>
<p><b>Jenni Fisher</b> Physiotherapy AT&amp;R</p>	<p><b>Michelle Wehi</b> Social Work AT&amp;R</p>	<p><b>Katherine Zhang</b> Dietician AT&amp;R</p>	<p><b>Victoria Harding</b> Occupational Therapist AT&amp;R</p>
<p><b>Mariette Boortman</b> Occupational Therapist AT&amp;R</p>	<p><b>Rainyzami Padona</b> ACNM Ward 5</p>	<p><b>Analiza Carnice</b> ACNM Ward 4 &amp; 5</p>	<p><b>Prem Kumar</b> Improvement Advisor Beyond 20,000 Days</p>
<p><b>Danni Farrell</b> Collaborative Project Manager Beyond 20,000 Days</p>			



From left: Michelle Wehi, Jenni Fisher, Leigh Haldane, Judith Gavin, Marlese Weaver, Michael McCallin and Ian Dodson

## References

1. Institute for Healthcare Improvement. The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: IHI; 2003.
2. Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The improvement guide: a practical approach to enhancing organizational performance (2nd edition). San Francisco: Jossey-Bass; 2009.
3. Ellis G, Whitehead MA, O'Neill D, Langhorne P, Robinson D. Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database of Systematic Reviews. 2011 Jul 6; (7):CD006211.
4. Wilber R. The risk assessment that reduced length of stay by 20% [Expert Insight]. The Advisory Board Company; 2013, May 20. Available from: <http://www.advisory.com/pt-pt/international/research/clinical-operations-board/expert-insights/2013/risk-assessment-reduce-los-20-percent>. Accessed 2013, May.
5. Dellefield ME. Interdisciplinary care planning and the written care plan in nursing homes: a critical review. Gerontologist. 2006 Feb;44(1):128-133.
6. Gjorup T, Aldershvile J, Jacobsen LA, Karle H, Kirkegaard BC, Pedersen SH, et al. "The good medical department: a discussion paper". Ugeskrift for Laeger. 1996;158 Suppl. 5. As cited in: From G, Pedersen LM, Hansen J, Morten C, Gjorup T, Thorsgaard N, et al. Evaluating two different methods of documenting care plans in medical records. Clinical Governance. 2003;8(2):138.
7. Cooper R, Meara M. The organizational huddle process -- optimum results through collaboration. Health Care Manager. 2002;21(2):12-16.
8. Weaver M, Gavin J. ACE care for elderly patients. Kai Tiaki: Nursing New Zealand. 2014;20(10):16-17.
9. Leukaemia & Blood Cancer New Zealand. Blood basics. Available from: [http://www.leukaemia.org.nz/section/about\\_diseases](http://www.leukaemia.org.nz/section/about_diseases). Accessed 2015, January 28.

## Background reading

Bowles KH, Holland DE, Potashnik SL. Implementation and testing of interdisciplinary decision support tools to standardize discharge planning. In NI 2012: Proceedings of the 11th International Congress on Nursing Informatics. 2012; 041.

Conroy SP, Ferguson C, Woodard J, Banerjee J. Interface geriatrics: evidence-based care for frail older people with medical crises. British Journal of Hospital Medicine. 2010 Feb;71(2):98-101.

Garcia-Perez L, Linertova R, Lorenzo-Riera A, Vazquez-Diaz JR, Duque-Gonzalez B, Sarria-Santamera A. Risk factors for hospital readmissions in elderly patients: a systemic review. Quarterly Journal of Medicine. 2011;104(8):639-651.

George J, Sturgess I, Purewal S, Baxter H. Improving quality and value in healthcare for frail older people. Quality in Ageing and Older Adults. 2007;8(4):4-9.

Gruneir A, Silver MJ, Rochon PA. Emergency department use by older adults: a literature review on trends, appropriateness and consequences of unmet health care needs. Medical Care Research & Review. 2011;68(2):131-155.

Sternberg SA, Wershof Schwartz A, Karunanathan S, Bergman H, Mark Clarfield A. The identification of frailty: a systematic literature review. Journal of the American Geriatrics Society. 2011;59(11):2129-2138.

Sutton M, Grimmer-Somers K, Jeffries L. Screening tools to identify hospitalised elderly patients at risk of functional decline: a systemic review. International Journal of Clinical Practice. 2008;62(12):1900-1909.

JAM Tool	
<b>Instructions:</b>	
<ul style="list-style-type: none"> <li>The total score will be out of 40.</li> <li>Each criterion is weighted to reflect changes in need for assistance and possible step down in level of care (Rest Home or Private Hospital).</li> <li>No criteria can score 0.</li> <li>Score is based on <b>CURRENT ACTUAL LEVEL</b>, not pre-morbid level.</li> </ul>	
<b>Family Support</b> – the number of significant others that are directly involved in patient care e.g. live with them and support or are involved daily	
1	More than two significant others
3	Two significant others
6	One significant other
<b>Mobility Aid</b> – a mobility aid is a stick/crutches/frame etc	
1	Independent with no mobility aid
3	Independent but uses a mobility aid
6	Uses a mobility aid and/or requires a person to supervise or assist
<b>Cognition</b> - Question the patient or family around orientation and memory to judge (acutely delirious should score 10).	
1	No deficit
3	Mild – moderate
10	Moderate – severe
<b>Continence</b> - Score 3 or 6 for any accidents or ongoing continence issues	
1	Fully continent or IDC
3	Urinary incontinent
6	Urinary and bowel incontinence
<b>Vision</b> – Visual aids may be glasses/lenses etc.	
1	Intact
3	Visual impairment but aids help
6	Visual impairment but no aids or aids DON'T help
<b>Malnutrition Risk</b> – Score 3 if recent unintentional weight loss. Score 6 if low BMI (<18.5) or significant unintentional weight loss. Take personal appearance into account e.g. frail, cachectic, obese.	
1	Low
3	Moderate
6	High
<b>Overall Score</b> - ___/40	
<ul style="list-style-type: none"> <li>A score of 20 or more indicates a higher likelihood of step down in level of care.</li> <li>A score of 14 or less indicates a low likelihood of step down in level of care.</li> <li>Patients who score 15 or more are most suitable for ACE model of care.</li> </ul>	

# APPENDIX B: ACE ADMISSION PLANNER

Patient Label		ADMISSION TO AT & R					
HANDOVER (Nurse to complete this section)							
Date _____		Time _____		Signature _____		Name _____	
Presenting conditions/concerns							
Medical History							
Investigations completed				Plan			
Known allergies/adverse reactions				Resuscitation Status:			
MROs				Alerts			
				Falls Risk <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Pressure Injury <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Confusion <input type="checkbox"/> Yes <input type="checkbox"/> No			
OBSERVATIONS						PUP score:	Initials:
Time	Temperature	Pulse	Blood Pressure	Respiration	O2 Sats	BSL	Weight

ABOUT ME		Date _____	Time _____
I would like to be called _____			
My preferred language is _____			
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No			
My rights have been discussed with me and pamphlet has been offered to me:			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
New Zealand resident <input type="checkbox"/> Yes <input type="checkbox"/> No			
Welcome Pack Given <input type="checkbox"/> Yes <input type="checkbox"/> No			
My family/whanau/partners in care			
I would like _____ involved in my care/treatment			
I would like _____ to be with me night and day if I wish			
Name	Relationship	Phone number	
CULTURAL AND SPIRITUAL : The following religious/cultural practices are important to me			Initials:
VALUABLES AND PERSONAL BELONGINGS			Initials:
Property	<input type="checkbox"/> I accept responsibility	<input type="checkbox"/> Given to family to take home	Or where stored for safekeeping:
Given to	Name:	Signature:	
Comments:			
Valuables	<input type="checkbox"/> I accept responsibility	<input type="checkbox"/> Given to family to take home:	Or where stored for safekeeping:
Given to	Name:	Signature:	
Comments:			



# APPENDIX B: ACE ADMISSION PLANNER

Patient Label		ADMISSION TO AT & R	
Do you have any problems or recent changes to:			Initials:
<b>Bladder</b>	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> IDC <input type="checkbox"/> Continence Aids Long Term <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Continence Aids		
<b>Bowel</b>	<input type="checkbox"/> Continent <input type="checkbox"/> Continence Aids <input type="checkbox"/> Incontinent <input type="checkbox"/> Constipation		
<b>Ostomy</b>	<input type="checkbox"/> Self Care	Products required:	
<input type="checkbox"/> I have my supplies with me	<input type="checkbox"/> My family will bring them in	Type:	
Is there anything else you would like to tell us:			
SAFETY RISKS			Initials:
Known MRO Positive <input type="checkbox"/> Yes <input type="checkbox"/> No Overseas Hospital for the last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No Inpatient in any Health Care Facility in the last 6 months including our hospital <input type="checkbox"/> Yes <input type="checkbox"/> No MRO Screening <input type="checkbox"/> MRSA <input type="checkbox"/> ESBL <input type="checkbox"/> VRE			
<input type="checkbox"/> Ward wristband applied			<input type="checkbox"/> Patient has been given welcome pack
<input type="checkbox"/> Orientated to ward, call bells, toilets			
<input type="checkbox"/> Falls Risk assessment done <input type="checkbox"/> Pressure Injury assessment <input type="checkbox"/> CAM scoring initiated			

Patient Label		ADMISSION TO AT & R	
<b>ORAL HEALTH SCREENING</b>			Initials:
<b>Dental Status</b>	(Ask)	<b>Nursing</b>	
<input type="checkbox"/> Has no teeth	<input type="checkbox"/> Wears upper dentures	<input type="checkbox"/> Storage container with patient name provided	
<input type="checkbox"/> Has most teeth	<input type="checkbox"/> Wears lower dentures	<input type="checkbox"/> Patient takes responsibility	
<input type="checkbox"/> Has own teeth	<input type="checkbox"/> Wears partial denture(s)	<input type="checkbox"/> Denture named	
<input type="checkbox"/> Has some teeth	<input type="checkbox"/> Dentures poorly fitted	<input type="checkbox"/> Requires adhesion	
<b>Oral Comfort</b>	(Ask)	<b>Rehab Assistant</b>	
<input type="checkbox"/> Pain from mouth	<input type="checkbox"/> Occasional pain from dentures	<input type="checkbox"/> RN informed	
<input type="checkbox"/> Pain from dentures	<input type="checkbox"/> Pain from gums		
<input type="checkbox"/> Mouth often painful	<input type="checkbox"/> Pain from teeth		
<b>Teeth and Gums</b>	(Observe)	<b>Rehab Assistant</b>	
<input type="checkbox"/> Teeth and gums look healthy	<input type="checkbox"/> Gums are red, swollen or bleeding	<input type="checkbox"/> RN informed	
<input type="checkbox"/> Teeth appear to have decay (holes)	<input type="checkbox"/> Gums appear to be receding		
<b>Tongue</b>	(Observe)	<b>Rehab Assistant</b>	
<input type="checkbox"/> Clean	<input type="checkbox"/> Coated	<input type="checkbox"/> RN informed	
<input type="checkbox"/> Dry			
<b>Oral Hygiene (Observe - look for FPT - food debris, plaque or tartar)</b>		<b>Rehab Assistant</b>	
<input type="checkbox"/> Good	<input type="checkbox"/> Adequate (FPT seen in one of two areas of mouth or on small area of dentures)	<input type="checkbox"/> RN informed	
<input type="checkbox"/> Poor (FPT seen in most areas of mouth or on dentures)	<input type="checkbox"/> Pocketing food in mouth		
<b>Oral Hygiene Ability</b>		<b>Rehab Assistant</b>	
<input type="checkbox"/> Can brush independently	<input type="checkbox"/> Needs some assistance	<input type="checkbox"/> RN informed	
<input type="checkbox"/> Information pamphlet given			
e-NUTRITION SCREEN (Dietetic Assistant)		Date: Time:	Initials:
Weight around 6 months ago:		Kg Date:	
Ulna length:                      cm	Height from ulna length:                      m		
<b>Appetite:</b>	<b>Oral intake:</b>	<input type="checkbox"/> Low	
		<input type="checkbox"/> Moderate risk	
<b>BMI:</b>	RA to provide "Your nutrition screening result" letter and "Eating for healthy older people" booklet		
<b>Main nutrition risk:</b>	Dietitian to review screening information and assess need for dietetic input.		
<input type="checkbox"/> High risk: Dietitian to assess			

# APPENDIX B: ACE ADMISSION PLANNER

Patient Label		ADMISSION TO AT & R	
HOME SITUATION (Social Worker)	Date: Time:	Initials:	
Living Situation _____		Alerts Identified on Pims	
Safety Alerts <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments _____		Comments: _____	
FAMILY/WHANAU/SOCIAL SUPPORTS			
Informal _____			
Formal _____			
Family/Whanau _____			
Comments _____			
Advanced care plan in place <input type="checkbox"/> Yes <input type="checkbox"/> No		Intervention Plan	
Finance/Legal <input type="checkbox"/> EPOA <input type="checkbox"/> NZ SUPER <input type="checkbox"/> CSC <input type="checkbox"/> WINZ		Comments: _____	
Comments: _____			
Is there anything else you would like to tell us?			

Patient Label		ADMISSION TO AT & R			
MOBILITY SAFETY SCREEN (PT/OT to complete)		Date: _____ Time: _____			
Informed Consent Gained to complete screen <input type="checkbox"/>		Independent	Supervision	Assist x 1	Assist x 2
People Present:					
BED MOBILITY	<input type="checkbox"/> No Equipment				
	<input type="checkbox"/> Other: _____				
TRANSFERS	<input type="checkbox"/> No equipment				
	<input type="checkbox"/> Walking Aid Type: _____				
	<input type="checkbox"/> Other: _____				
MOBILITY	<input type="checkbox"/> No aid				
	<input type="checkbox"/> Walking Aid Type: _____				
	<input type="checkbox"/> DO NOT MOBILISE				
	<input type="checkbox"/> Stairs: _____				
TOILETING	<input type="checkbox"/> No equipment				
	<input type="checkbox"/> Other: _____				
SHOWERING	<input type="checkbox"/> No equipment				
	<input type="checkbox"/> Other: _____				
SEATING	<input type="checkbox"/> Type: _____				
ANALYSIS					
PRECAUTIONS					
OUTCOME		<input type="checkbox"/> Discharge PT	<input type="checkbox"/> F/U PT	<input type="checkbox"/> F/U OT	
Signature: _____					

# APPENDIX C: ACE CARE PLANNER

## DAILY CARE PLAN

Goal Discharge Date: \_\_\_\_\_  
 Reason for Admission: \_\_\_\_\_

Current Problems	Interventions Date:														
Risk assessments -															
Waterlow:															
Falls:															
CAM:															
Hearing/Vision impaired:															
Continence:															
ACE HUDDLE: Barriers to discharge: or Rehabilitation Goals															
Nutrition/Hydration	N			N			N			N			N		
Bowels:	AM														
Indept/Commode/Bed/Stoma	PM														
ADL's - Shower:           Bed/Chair/Indept Dentures:        Yes    No Hearing Aids:   Yes    No															
IV Lines:	IV Site: Date inserted: Removed:														
IV Lines checked:	N	AM	PM												
O2/suction at bedside:	N	AM	PM												
Staff's Signature/shift:	N	AM	PM												

## APPENDIX C: ACE CARE PLANNER

Current Problems	Interventions Date:				
Risk assessments -					
Waterlow:					
Falls:					
CAM:					
Hearing/Vision impaired:					
Continence:					
ACE HUDDLE: Barriers to discharge: or Rehabilitation Goals					
Nutrition/Hydration	N	N	N	N	N
Bowels:	AM	AM	AM	AM	AM
Indept/Commode/Bed/Stoma	PM	PM	PM	PM	PM
ADL's - Shower:            Bed/Chair/Indept Dentures:        Yes    No Hearing Aids:    Yes    No					
IV Lines:	IV Site: Date inserted: Removed:				
IV Lines checked:	N    AM    PM				
O2/suction at bedside:	N    AM    PM				
Procedures/Referrals Discharge Planning/ Family Involvement					
Education Patient/Family					
Staff's Signature/shift:	N    AM    PM				

## POSITION DESCRIPTION

### Clinical Nurse Specialist, Gerontology Adult Rehabilitation and Health of Older People



#### PURPOSE OF THE POSITION

- Provide comprehensive clinical nursing expertise for Health of Older People including patients in an Acute geriatric setting
- Provide clinical nursing leadership to ensure patient treatment and care planning is comprehensively coordinated, by demonstrating best practice in Acute Geriatrics
- Promote clinical coordination that supports an interdisciplinary approach to care in an effective practice environment
- Participate in the timely transfer of patients to the Acute Geriatrics setting

#### PROBLEM COMPLEXITY

The Clinical Nurse Specialist, Gerontology, will be challenged by a wide range of complex and unpredictable issues associated with clinical practice on a daily basis. There will be a requirement to prioritise issues and negotiate timeframes while providing a high quality customer service in AT&R and the organisation.

#### SCOPE FOR ACTION

The Clinical Nurse Specialist, Gerontology will be accountable for the comprehensive assessments and coordination of care of patients in the Acute Care of Elderly model of care. It will be expected problem solving skills will be used to develop innovative approaches to issues on a day to day basis.

The Clinical Nurse Specialist, Gerontology will need to negotiate with and co-ordinate with other AT&R team members as well as other staff within the organisation to develop solutions. It is expected that those solutions are best practise.

#### DIMENSION OF THE POSITION

The Clinical Nurse Specialist, Gerontology is responsible to the Service Manager and the Clinical Nurse Director, ARHOP for the achievement of objectives and goals for the service. The Clinical Nurse Specialist, Gerontology is accountable to the Clinical Nurse Director for professional development and clinical practice.

#### POSITIONS REPORTING

Directly Nil

#### COMMUNICATION AND INTERPERSONAL SKILLS

Will be required to interact on a regular basis with a range of CMDHB staff, General Practitioners, Practice Nurses and Aged Related residential care staff members including:

#### Internally

Nursing staff including: Director of Nursing, Clinical Nurse Director, Nurse Managers, Charge Nurse Managers, Clinical Nurse Specialists, Nurse Educators Registered Nurses  
 Medical staff- Clinical Director, Clinical Head, Senior Medical Officers, Registrars, and House Surgeons  
 Allied Health professionals  
 Service Managers  
 Emergency Care  
 Middlemore Central

**Externally** there will be contact with:

Patients  
 Caregivers and their families /Whaanau  
 Other DHB staff  
 General Practitioners and Practice Nurses  
 Managers of Age Related Residential Care facilities  
 Funding Agencies  
 External Medical and/or Care providers

The employee will be required to have a very high level of communication skills including negotiating and influencing skills, tact and diplomacy and the ability to influence. Information will often be required to be handled in a discreet and sensitive manner.

In conflict, situations will be required to exercise sound judgement, negotiation and persuasiveness skills, toward facilitating a workable outcome.

## NATURE AND SCOPE OF RESPONSIBILITIES

Key Accountabilities	Standards / Achievements
<b>Advanced clinical practice and leadership</b>	Participates in the triage of patients referred to Acute Care of Elderly (ACE) from Emergency Care and Medical Services  Undertakes a comprehensive and accurate nursing assessment of patients referred to ACE model of care  Discusses complex referrals and assessments with the admitting Medical Officer prior to acceptance into the ACE model of care  Demonstrates and understands the implications of clinical decision making and considers multiple solutions to given issues  Identifies and utilises the Assessment, Treatment and Rehabilitation (AT&R) models of care framework to ensure patients are transferred to the appropriate ward/ location including Pukekohe and Franklin Locality  Provides clinical cover for CNS, BC as required  Demonstrates a high level of critical thinking and complex problem solving skills to minimise the risk to the patient and the organisation  Provides clinical support for all staff to ensure an optimum outcome is achieved for patients  Participates in multi disciplinary team meetings to co-ordinate discharge planning for patients in Acute Geriatric model of care
<b>Leadership</b>	Demonstrates as an effective role model by demonstrating advanced clinical competence  Oversees the assessment, planning implementation and evaluation of nursing care within the model of care  Provides clinical support to nursing staff in collaboration with the Nurse Educator  Works collaboratively with all members of the team and the patient to ensure an optimum outcome is achieved for the patient  Coordinates family meetings and discharge planning for ACE patients  Discusses with the Clinical Head or delegate, issues relating to individual patients in ACE model of care  Develops and implements a systematic process for the collection of data for monthly reporting to the Service Manager

<p><b>Effective interpersonal relationships</b></p>	<p>Advocates on behalf of patient/ family/ colleagues as appropriate and in a culturally safe manner</p> <p>Advocates for patients and their families to ensure they understand the plan of care and the available treatment options in AT&amp;R</p> <p>Communicates effectively with patients , staff, and families</p> <p>Works collaboratively with CNS Bed Coordination, Middlemore Central, Charge Nurse Managers, Medical staff and Allied Health to ensure the right patient is in the right bed</p> <p>Works collaboratively with AT&amp;R administration staff in areas of triage, referrals and any other clinical questions</p> <p>Ensures individual documentation is accurate and maintains confidentiality of information within a legal /ethical framework</p> <p>Provides comprehensive referrals to other health professionals as appropriate</p>	<p><b>Professional development</b></p>	<p>Maintains own clinical competencies and complies with the requirements of Health Practitioners Competency Assurance Act 2003</p> <p>Maintains a current Professional Development and Recognition programme (PDRP) portfolio</p> <p>Participates in annual performance review process to identify ongoing professional development requirements</p> <p>Maintains and updates own knowledge related to Adult Rehabilitation and Health of Older People</p> <p>Attends educational opportunities and conferences relevant to the role and scope of practice and uses this knowledge to improve practice</p> <p>Undertakes CMDHB Tikanga Best Practice training and implements it into clinical practice service provision</p> <p>Actively participates in relevant professional organisations</p> <p>Provides leadership in preceptoring nurses, students and new graduates and other health professionals during orientation</p> <p>Provides leadership to ensure there is a clear understanding of roles of delegation and direction of nursing</p> <p>Critiques research findings and utilises these as a base for best practice</p> <p>Role models behaviours and practices consistent senior nursing practice</p>
<p><b>Quality improvement</b></p>	<p>Contributes to the development of standards of practice, protocols and policies within the service</p> <p>Complies with organisational clinical policies and guidelines</p> <p>Collects information on service provision to evaluate the service effectiveness</p> <p>Contributes to research and quality improvement projects relevant to the service</p> <p>Utilises Ko Awatea for access to quality and service improvement methodology</p>	<p><b>Health and Safety :</b> Recognises individual responsibility for workplace Health &amp; Safety under the Health and Safety Act 1992</p>	<p>Counties Manukau DHB Health and Safety policies are read and understood and relevant procedures are applied to own work</p> <p>Infection control issues are identified and managed to ensure that the patient's safety is met.</p> <p>CMDHB incident reporting policies meet compliance</p> <p>Workplace hazards are identified and adequate controls put in place.</p>

<p><b>Cultural Competency</b></p> <p><b>Commitment to the Principles of Treaty of Waitangi</b></p> <p><b>Honouring Cultural Diversity</b></p>	<p>Respect, sensitivity, cultural awareness is evident in interpersonal relationships.</p> <p>Cultural differences are acknowledged by respecting spiritual beliefs, cultural practices and lifestyle choices of patients and their families/whaanau</p> <p>Work practices are consistent with Tikanga Best Practice</p>
<p><b>Utilise Information technology</b></p>	<p>Demonstrates abilities to access and use available clinical information systems.</p> <p>Is conversant with applications required for specific discipline/role. For example, PIMS including Contacts and diaries, Concerto, Outlook, Incident Reporting System</p> <p>Maintains own professional development by attending relevant IT educational programmes</p>

### PROBLEM COMPLEXITY

The Clinical Nurse Specialist, Gerontology, will be challenged by a wide range of complex and unpredictable issues associated with clinical practice on a daily basis. There will be a requirement to prioritise issues and negotiate timeframes while providing a high quality customer service in AT&R and the organisation.

### SCOPE FOR ACTION

The Clinical Nurse Specialist, Gerontology will be accountable for the comprehensive assessments and coordination of care of patients in the Acute Care of Elderly model of care. It will be expected problem solving skills will be used to develop innovative approaches to issues on a day to day basis. The Clinical Nurse Specialist, Gerontology will need to negotiate with and co-ordinate with other AT&R team members as well as other staff within the organisation to develop solutions. It is expected that those solutions are best practise.

### DIMENSION OF THE POSITION

The Clinical Nurse Specialist, Gerontology is responsible to the Service Manager and the Clinical Nurse Director, ARHOP for the achievement of objectives and goals for the service. The Clinical Nurse Specialist, Gerontology is accountable to the Clinical Nurse Director for professional development and clinical practice.

### POSITIONS REPORTING

Directly Nil

### COMMUNICATION AND INTERPERSONAL SKILLS

Will be required to interact on a regular basis with a range of CMDHB staff, General Practitioners, Practice Nurses and Aged Related residential care staff members including:

#### Internally

- Nursing staff including: Director of Nursing, Clinical Nurse Director, Nurse Managers, Charge Nurse Managers, Clinical Nurse Specialists, Nurse Educators Registered Nurses
- Medical staff- Clinical Director, Clinical Head, Senior Medical Officers, Registrars, and House Surgeons
- Allied Health professionals
- Service Managers
- Emergency Care
- Middlemore Central

#### Externally there will be contact with:

- Patients
- Caregivers and their families /Whaanau
- Other DHB staff
- General Practitioners and Practice Nurses
- Managers of Age Related Residential Care facilities
- Funding Agencies
- External Medical and/or Care providers

The employee will be required to have a very high level of communication skills including negotiating and influencing skills, tact and diplomacy and the ability to influence. Information will often be required to be handled in a discreet and sensitive manner.

In conflict, situations will be required to exercise sound judgement, negotiation and persuasiveness skills, toward facilitating a workable outcome.

### PERSON SPECIFICATIONS

	ESSENTIAL	HIGHLY DESIRABLE
<b>EDUCATION</b>	<ul style="list-style-type: none"> <li>• Registered Nurse with current New Zealand practising certificate</li> <li>• Postgraduate Diploma (or in progress)</li> <li>• Has a professional development plan and /or career plan</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Masters Degree</li> </ul>
<b>EXPERIENCE/ KNOWLEDGE</b>	<ol style="list-style-type: none"> <li>1. A minimum of five years recent clinical experience in Health of Older People/ Rehabilitation/ Medicine</li> <li>2. Functioning at RN Expert or Senior Nurse level on the PDRP</li> <li>3. Demonstrated ability in advance health assessment and diagnostic reasoning nursing practice</li> <li>4. Knowledge of current issues within Nursing and Health of Older People/ Rehabilitation</li> <li>5. Competent knowledge and understanding of medico/legal and ethical responsibilities.</li> </ol>	<ul style="list-style-type: none"> <li>• Demonstrated ability in the development and management of staff.</li> </ul>
<b>SPECIFIC SKILLS</b>	<ol style="list-style-type: none"> <li>1. Clinical expertise especially in clinical assessment &amp; clinical reasoning</li> <li>2. Demonstrated critical thinking and analytical skills</li> <li>3. Clinical judgement and decision making</li> <li>4. Demonstrated ability in problem solving, priority setting, and planning</li> </ol> <ul style="list-style-type: none"> <li>• Ability to critique research and use it as the basis of practice</li> <li>• Demonstrated ability to self evaluate and reflect on practice</li> <li>• Demonstrated ability to work independently and be a member of a team</li> <li>• Demonstrated leadership and management</li> <li>• Demonstrated ability in negotiation/conflict management skills</li> <li>• Demonstrated ability to communicate effectively at all levels of the organisation and to establish effective networks</li> <li>• Work collaboratively</li> <li>• Computer literacy including report writing</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrated research skills</li> </ul> <ol style="list-style-type: none"> <li>1. Articulate scope of nursing practice and its advancement</li> <li>2. Demonstrated ability in expert practice, working collaboratively across settings and with an interdisciplinary environment</li> <li>3. Demonstrated ability in effectiveness nursing leadership</li> <li>4. Business planning skills</li> </ol>
<b>PERSONAL and PROFESSIONAL QUALITIES</b>	<ol style="list-style-type: none"> <li>1. High standard of professionalism and integrity</li> <li>2. A passion for improving Health of Older People and Rehabilitation nursing and standards of care</li> <li>3. Demonstrated patient focused care</li> <li>4. Demonstrated clinical leadership.</li> <li>5. A commitment to cultural safety and its application to nursing practice</li> <li>6. Improving nursing practice and standards of care</li> <li>7. A strong commitment and genuine interest in quality and service</li> <li>8. A commitment to the development of the nursing profession within CMDHB</li> <li>9. Membership of relevant, professional/other organisations</li> </ol>	<ul style="list-style-type: none"> <li>• Active involvement in relevant, professional/other organisations</li> <li>• Knowledge of Ministry of Health contracts</li> </ul>

ACE Huddle Guideline	
<b>Aim</b> To have a forum on Mondays, Wednesdays and Fridays for Multidisciplinary Team discussion of ACE patients focusing on Goal Discharge Date (GDD) and barriers to discharge.	<b>Core huddle members</b> <ul style="list-style-type: none"> <li>• Doctor</li> <li>• Nurse</li> <li>• Physiotherapist</li> <li>• Occupational Therapist</li> <li>• Social Worker.</li> </ul>
Role	Responsibility
<b>Facilitator</b>	<ul style="list-style-type: none"> <li>• Huddle team members (excluding doctors) to individually facilitate ACE Huddle on a weekly roster</li> <li>• Prepare the folder</li> <li>• Document feedback from the Huddle</li> <li>• Encourage discussion regarding GDD</li> <li>• Keep Huddle members focused on tasks</li> <li>• File ACE Huddle Record Sheet in clinical notes on discharge</li> </ul>
<b>Team members</b>	<ul style="list-style-type: none"> <li>• Be prompt and ready for 11:30am start on Monday, Wednesday and Friday</li> <li>• Be prepared and able to provide update on patients' progress</li> <li>• Be open to discussion and take responsibility for actions if needed from own discipline</li> </ul>
<b>Geriatric Clinical Nurse Specialist or Senior Nurse</b>	<ul style="list-style-type: none"> <li>• Prepare handover form regarding new admissions and place in Huddle file</li> <li>• Provide nursing update at the Huddle</li> <li>• Liaise with doctors regarding GDD and outstanding medical issues if doctors unavailable</li> <li>• Capture any changes/barriers to GDD on Travelling Sheet and update the whiteboard</li> <li>• Capture transfers from ACE to AT&amp;R on Travelling Sheet and update the whiteboard</li> <li>• Handover to Ward Clerk regarding discharges and transfers of ACE patients to AT&amp;R by using yellow form 'ACE to ATR'</li> <li>• Inform Ward Clerk of requested Family Meetings (FMs)</li> </ul>
<b>Ward Clerk</b>	<ul style="list-style-type: none"> <li>• Complete admin work to transfer ACE patients to AT&amp;R</li> <li>• Arrange FMs as requested</li> </ul>

Process and Procedure	
Folder preparation	
<b>Step 1</b>	Collect Travelling Sheet from Ward Clerk
<b>Step 2</b>	Remove discharged patients from previous day and place in back of file
<b>Step 3</b>	Arrange patients under Consultants in order of WIMS
<b>Step 4</b>	Ensure copy of admission documents is in place with ID stickers and blank ACE Huddle Record Sheet attached
<b>Step 5</b>	Check inside front cover to ensure Record Sheet copies are available (white and purple)
Process of Huddle	
<ul style="list-style-type: none"> <li>• <b>ACE Huddle to start at 11:30 am</b></li> <li>• <b>Meeting to last for approximately 30minutes</b></li> </ul>	
Facilitator introduction	
Start with GDD, current Length Of Stay	
Overview/feedback from previous Huddle Record Sheet discipline input	
Huddle members give current update of patients status and barriers to/action required for discharge	
Facilitator to set up/review GDD with Huddle members	
Facilitator/Clinical Nurse Specialist to give Huddle handover regarding new admissions	
Geriatric Clinical Nurse Specialist / Senior Nurse to handover to Ward Clerk regarding discharges, transfers of ACE patients to AT&R and requested FMs	
Clinical Nurse Specialist / Senior Nurse to liaise with doctors regarding GDD and outstanding medical issues if doctors unavailable	



Middlemore Hospital  
**Medical Record**  
**Acute - Health Older Person**  
 (ACE to AT&R Transfer)

---

**Mrs Cold POWER \***  
 PRP1660  
 [DoB: 18/07/1990] Female  
 Flat 1/44 Carlos Drive  
 Flat Bush, Auckland 2016  
 New Zealand  
 Ph: 09 276 4444

**To: GP**

**Cc:**

**Admitted:** 20/05/2015 13:01

**Discharged On:** 20/05/2015 13:02  
**Ward/Location:**

**Transfer Details**

**Mr**

**Has been on Ward 5 for an acute episode of**

**Previous level of function**

**Current level of function**

**Mrs**

**and has been transferred to rehabilitation for**

Complex discharge planning

Reconditioning

AT & R

FIM

**GP Notification**

Please note a comprehensive Transfer of Care Document will be completed and messaged to you when patient is discharged from rehabilitation services

**Clinician:** (Non-Clinical Support)

**Signature:** \_\_\_\_\_  
**Date:** 20/05/2015 13:02

\* Not a real patient



**IO AWATEA**  
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

  
**COUNTIES  
MANUKAU**  
HEALTH