1. **Clinical Audit of Dementia Care: A Quality Improvement Initiative – preliminary results**

**Authors:** Dr M. Joshipura, Dr T.A Izukawa, Dr B. Goldlist, Dr M. Nicula, Dr M Zorzitto, Dr M .Norris, Dr Joyce Lee, Dr Barbara Liu.
Regional Geriatric Program of Toronto and the University of Toronto

**Introduction**
Clinicians and policy makers are increasingly aware of the need to improve the quality of health care delivery. Quality indicators for dementia care have been developed by the American College of Physicians Assessing Care in Older Vulnerable Adults (ACOVE). The objective of this Quality improvement project was to audit practice and improve the quality of dementia care delivered in geriatric outpatient clinics by the geriatricians affiliated with the RGP and the University of Toronto

**Methods**
A data collection tool was developed and used to extract information regarding the performance of 19 quality indicators. A retrospective audit was performed on a convenience sampling of sequential ambulatory geriatric clinic charts which were met eligibility criteria: a new consultation seen between July 2006 and June 2007 in which the main issue identified was dementia. Documentation of the performance of the identified quality indicators was documented through the audit. Indicators with less than 80% documentation were flagged as needing improvement. Each participating received a summary of their own performance and the group mean.

**Results**
Ten geriatricians volunteered to participate. One hundred and seven charts were included in the audit. Trends in the aggregate data were analyzed by a steering committee. Enabling tools (reminder sheets, data collection forms and information pamphlets) were developed to address potential barriers to provision of quality care in dementia. The majority of quality indicators (eleven out of nineteen) were documented in more than 80% of cases. There were eight issues with suboptimal documentation (<80%). These were educational level of patient; wandering, fire –water safety, home safety assessment, caregiver stress, driving and POA for finances. The use of the enabling tools was promoted through individualized physician “detailing”. A repeat audit will take place in 3 to 4 months to determine if there was any change in practice.

**Conclusion:** Geriatricians in this audit are presently meeting benchmarks for quality dementia care in 11 out of 19 ACOVE indicators included in the audit. Areas with suboptimal documentation were targeted for a quality improvement intervention.

2. **SAFE Clinic & Interprofessional Leadership**

**Authors:** Michelle Acorn and Laura McLeod.
Lakeridge Health

The S.A.F.E. Clinic, Specialized Assessment of the Frail Elderly is a geriatric ambulatory clinic based on an interprofessional model of care. A comprehensive geriatric assessment is an evidenced based practice that identifies and treats reversible threats and prescribes supportive services to maximize independence. The goals of the SAFE clinic are to optimize function and quality of life for seniors, allow seniors to continue living in the community, decrease ER visits, minimize admission from ER departments and reduce length of stay in hospital for seniors.

We have linked with the CE LHIN and RGP to education and precept NPs in the LTC Outreach initiative. The SAFE team is also participating in an Interprofessional Leadership Research Project and approached Home At Last (HAL) as community partner. There are times where seniors attend SAFE alone or with aging family/friend supports. Without sufficient supports at home to assist with implementing the recommendations care is challenged. Senior’s have difficulty navigating and coordinating of the health system.

The goal of this project is to showcase SAFE services, strengthen interprofessional relationships between SAFE and Home At Last in an effort to improve access and safety to support seniors’ health and keep them SAFE!

3. **Preventing Admissions to Hospital: A New Approach to Managing Change of Health Status in Long Term Care**

**Author:** Deborah Brown-Farrell, Sunnybrook Health Sciences Centre

In 2006-2007 almost 200,000 Canadians lived in continuing care settings such as nursing homes and chronic care facilities. Recent reports have shown that while these residents are older and more medically complex than ever before, the facilities they reside in are not often equipped to deal with their complex health care needs. Consequently, many residents have unplanned transfers to hospital care that result in long delays in the emergency department and the acquisition of iatrogenic illnesses. In a large university based veteran care facility, a unique approach was developed to prevent unnecessary transfers to emergency care and provide the staff with the process, knowledge and tools for managing change in health status. Lead by an acute care trained Nurse Practitioner, an interprofessional clinical practice guideline was developed to assist staff with risk identification, assessment, communication, treatment and monitoring interventions for residents experiencing the common illnesses and conditions that often precipitate transfers to acute care.
Implementation processes included initial mass education and weekly case reviews to enhance clinical reasoning and judgment. The introduction of the Nurse Practitioner role focused on working with the residents, families and the interprofessional team, to assist with the interpretation of symptomatology, initiation of prompt treatment and continued monitoring.

Process data for the improvement of practice was generally positive with suggestions for continued improvement. Outcome data for the number of residents sent to emergency care also indicated a decrease in total numbers. With an increased focus on accountability for patient safety, efficiency and appropriate allocation of resources, it is important for administrators to examine options for enhancing the potential of present staffing models, funding frameworks and the approach to assessment of residents with complex care needs, in order to prevent unnecessary transfers to hospitals.

4. Integrated Geriatric and Psychogeriatric Outreach Services for Seniors in the Community


Regional Geriatric Program of Toronto, St. Joseph’s Healthcare Centre, St. Michael’s Hospital, COTA Health, Toronto Central Community Care Access Centre, Centre for Addiction and Mental Health)

**Context:** Homebound seniors are at high risk for adverse outcomes and loss of the capacity for living in their home. These seniors require outreach services delivered by many organizations such as specialized geriatric and psychogeriatric outreach teams, CCACs, emergency departments and community support agencies. The ability of the providers of these services to deliver efficient and effective inter-organizational and collaborative shared care has proven a challenge. Systemic barriers exist in care processes, human resource scarcity and integration skill sets. **Description of initiative:** The Regional Geriatric Program of Toronto and its partners launched a new specialized geriatric service Outreach Team to serve high need areas of the Toronto Central LHIN. The team provides integrated Geriatric Medicine and Geriatric Psychiatry outreach and intensive/enhanced case management services. This service focuses on the frail, marginalized, at risk seniors with geriatric and/or psychogeriatric issues. **Goal of initiative:** To strengthen the circle of care that supports frail and marginalized homebound seniors and preserves their ability to age at home. **Main outcome of initiative:** Integration of specialized outreach services based on a common motivation to provide the right care, in the right place at the right time. **Results:** Joint planning completed. Implementation and evaluation is a work-in-progress until March 31, 2010.

**Conclusion:** This presentation will provide an example of integration planning, implementation and evaluation at the program/service level. Partners’ role and responsibilities, risks and mitigation strategies, performance indicators and lessons learned from the joint planning and implementation activities will be discussed.

5. Alternate Level of Care Activation Project

**Authors:** J. Dunn, L. Hay, M. Aschibar, G. Sadler, C. Smith-Romeril.

Ross Memorial Hospital, Lindsay

The Central East LHIN Alternate Level of Care (ALC) Task Group identified issues impacting in-patient flow related to patients designated ALC

**Key issues included:**
- the prevention of deconditioning and iatrogenesis
- encouraging activation and identifying opportunities for recovery
- reducing risk of institutionalization

The ALC Activation Project was therefore developed based on recommendations from the CE LHIN ALC Task Group Report

6. Geriatrics, Inter-Professional Practice and Inter-Organizational Collaboration: The GiiC Initiative in the Province of Ontario

**Author:** Dr. David Ryan, Dr. Barbara Liu, Ken Wong, Regional Geriatric Program of Toronto

**Introduction:** Population aging and especially frailty present significant challenges to the health care system in the Province of Ontario in Canada. Health professionals are presently being insufficiently prepared in the competencies required to care for frail seniors - clinical geriatrics, inter-professional practice (IPP) and inter-organizational collaboration (IOC). **Methods:** To help build these competencies an inter-professional team of consultants has drawn upon the knowledge base within the co-investigators organizations, prepared an evidence-based GiiC toolkit and implemented a province wide knowledge-to-practice program to train and support a resource person within 200 family health teams and community health centers across the province.

**Results:** A descriptive design informed by a blend of qualitative and quantitative methods indicates high levels of satisfaction with the knowledge to practice processes, a 75% penetration rate in eligible organizations, an increase in trainee perceptions of self-confidence, an increase in GiiC practices, and enhanced linkage between regional geriatric programs, family health teams and community health centers across the province.
Conclusions: The GiiC initiative seems a productive approach to enhancing the distribution of GiiC competencies in two kinds of primary care practice settings and provides a framework upon which to build service collaboration between three forms of health service providers.

7. The Senior Friendly Hospital Toolkit

Authors: Ken Wong, Dr. David Ryan, Dr. Barbara Liu, Marlene Awad,
Regional Geriatric Program of Toronto.

Seniors are the greatest consumers of health care services in Ontario. In 2000-2001, seniors accounted for 63% of hospital days and 43% of healthcare costs. Frail seniors represent 3% of our population, yet account for 30% of healthcare expenditures. The mounting challenges to the health care system become apparent when considering that the population of older seniors over 85 years of age is expected to more than double by the year 2026. As this happens, hospitals will increasingly need to ensure that their services effectively meet the needs of older adults. Hospitalization can be a pivotal event in a senior's life; either adding years and quality or creating potential complications. Without senior friendly processes in place, seniors have higher rates of adverse events such as surgical complications, nosocomial infection, hospital acquired delirium, and injury from falls. In turn, this may play a role in extending the length of hospital stay, and may increase the risk of re-admission and decrease capacity for independent living.

The Regional Geriatric Program of Toronto has built a web-based resource to assist hospitals in their care of older adults. The Senior Friendly Hospital Toolkit is a compilation of resources developed by members of the Toronto RGP's network of 28 hospitals. It brings knowledge-to-practice resources in the five domains outlined in the RGP's Senior Friendly Hospital framework: Processes of Care, Physical Environment, Emotional and Behavioural Environment, Ethics in Clinical Care and Research, and Organizational Support. By providing easy access to high quality, evidence based resources and by promoting the sharing of innovation, the Senior Friendly Hospital Toolkit will make it easier for hospitals to meet the growing challenge of our aging population.

8. The GiiC Initiative: A Profile of Geriatric Services and Inter-Professional Practice in Primary Health Care Teams in Ontario

Authors: Dr David Ryan, Dr Barbara Liu, and Ken Wong
Regional Geriatric Program of Toronto.

Frail seniors need health care providers with high levels of ability in three areas: geriatrics, inter-professional practice, and inter-organizational collaboration (GiiC). The GiiC initiative was a collaborative effort of the Regional Geriatric Programs of Ontario, the Centre for Education and Research on Aging and Health at Lakehead University, and the North Eastern Ontario Specialized Geriatric Services. The initiative sought to assist Family Health Teams (FHTs) and Community Health Centres (CHCs) across the province of Ontario to develop their GiiC capabilities through a series of knowledge-to-practice workshops, online resources, edumetric teamwork reviews and coaching from a team of GiiC resource consultants.

Eighty-two percent of the province's FHTs and CHCs participated in the project, and the project evaluation provides insight into the nature of GiiC practices across Ontario. FHTs and CHCs have similar proportions of seniors in their patient rosters - 22% to 25% are "young-old" clients and 10% to 13% are 75 years of age or older. While FHTs report a higher proportion having staff with specialized training in geriatrics than CHCs (52% vs 32%), CHCs are more likely to provide designated geriatric services (24% vs 16% in FHTs). When geriatric practice is considered, standardized clinical tools are most likely to be in use in areas of cognitive and depression screening while standardized tools for abuse screening, falls risk assessment, delirium screening, safe driving assessment, polypharmacy reviews and continence screening are less likely to be in place.

Results from the use of the Dimensions of Teamwork (DTEAM) Survey and from social networking analyses provide a profile of teamwork in FHTs and CHCs. While FHTs and CHCs have slightly higher levels of teamwork than a standardization group comprised of a health care teams from a variety of contexts, only 16% were identified as high performance health care teams.

Overall, the results validate the purpose of the GiiC initiative - to help family health teams and community health centers continue to develop their capacity to care for frail seniors. The project was rated very highly by FHT/CHC participants and the project’s online toolkit at http://giic.rgps.on.ca continues to be in high use. In future research, we anticipate bringing the GiiC process to other health care sectors and examining the initiative’s impact on frailty focused care.
End of Life Care. Polypharmacy and Pharmacokinetic changes
Dementia/Depression

Methodology:

Background:

Findings:

Conclusion:

9. “What did they tell me to do?” - An Electronic Discharge Summary for Seniors in the ED

Authors: Carla Loftus, Don Melady, Nana Asomaning
Mount Sinai Hospital

Emergency department (ED) visits can be an overwhelming experience for elderly persons. Complex elderly patients often see different health care providers who give verbal or hastily written discharge/follow up instructions. At home, potential for inaccurate recall may negate the impact of the ED visit. To improve the patient experience for elderly patients discharged from ED, the ED inter-professional team at Mount Sinai Hospital developed an electronic Geriatric Discharge Summary (GDS). Feedback and review of the tool was given by Friendly to Seniors, a geriatric peer-support group.
The GDS is produced by team members (RN, MD, OT, PT, SW, CCAC) who enter information about care, diagnosis, medication changes, home care services, follow-up tests and appointments, and other instructions, into the electronic template. A large-text discharge plan is provided to the patient and reviewed to ensure agreement with the plan. A copy is saved in the patient’s electronic health record to allow access at future ED visits and by other hospitals.

As an innovative use of technology, the GDS improves the patient experience by enhancing communication and involvement in care plan development, thereby fostering patient- and family-centered care. Patient safety is promoted by educating the patient about their ED and future care.

10. The Hospitalized Older Person Education Curriculum H.O.P.E (supported by the Education Development Fund)


Sunnybrook Health Sciences Centre

Background: The H.O.P.E curriculum engaged five Trainees in the Hospitalist Training Program to develop improved knowledge, skills and attitudes in caring for hospitalized seniors. This evidence-based geriatric curriculum for hospitalists was designed, developed, implemented and evaluated with the goal of enhancing practice and patient safety within the current hospitalist curriculum which is tailored after the core competencies of the society of hospital medicine.

Methodology: An assessment of educational needs was obtained from multiple choice pre-test questions as well as attitude, knowledge and skills surveys. Each trainee was assigned a presentation which covered the following topics: Dementia/Depression, fall and Least Restraints, Incontinence, Polypharmacy and Pharmacokinetic changes with Aging and End of Life Care.

Two Sunnybrook Health Sciences’ Centre staff geriatricians covered the following topics: Comprehensive Geriatric assessment, Delirium and Hazards of Hospitalization/patient safety and End of Life Care. Wound care was taught by a staff family physician. Evaluations from each teaching sessions were collected. Two quality improvement projects have been initiated which may improve care of hospitalized seniors. Post test knowledge attitude and skills surveys are planned in April while a focus group survey is planned in May.

Results: The trainee’s background specialization included; Family Medicine, Geriatric medicine, Cardiology and General internal medicine. The result of the pre-test illustrates significant knowledge deficits in the area of care of the hospitalized seniors. The average score on the pre-test was a score of 17/29 with the highest score being 22/29 and the lowest score being 11/29. Trainees found the teaching session highly relevant to their work and the quality of the session was rated mostly good to excellent.

Conclusion: International medical graduates can successfully engage in an evidence-based hospitalist geriatric curriculum that is highly relevant to their work and effectively teach each other.

11. Bridging the Gaps in Geriatric Patient Safety

Authors: Jenna Evans, PhD Student, University of Toronto, Betanya Tefera, BHS Graduate, York University

Background: Current patient safety standards lack sensitivity to the unique needs of geriatric patients in hospital. Seniors currently account for 63% of hospital days; have higher rates of adverse events, surgical complications, and nosocomial infections; and are at greater risk for functional decline while in hospital.

Approach: We conducted literature reviews and interviews with experts on patient safety, geriatric care, and international accreditation processes. With this data and information we performed a gap analysis, in partnership with the Regional Geriatric Program of Toronto (RGP), to identify areas for improvement in the “senior-sensitivity” of existing hospital patient safety accreditation standards in Canada.

Findings: Several areas for improvement in hospital safety culture, education, and policy are outlined with corresponding suggested organizational practices for bridging these gaps.

Conclusion: We recommend that the RGP prioritize the suggested organizational practices using expert consensus, partner with other interested organizations and professional associations, and attempt to influence Accreditation Canada to both (1) develop a senior-specific safety program for hospitals and (2) integrate senior-specific standards into their general Patient Safety Strategy. Through accreditation, we can enable hospitals to meet the unique needs of their primary client, the geriatric patient.
12. Strengthening Sunnybrook’s Commitment to Senior Friendly Care

Authors: Dr. Susan VanDeVelde-Coke, Dr. Barbara Liu, Deborah Brown-Farrell, Betsy Jackson, Debbie Lai and the Sunnybrook Senior Friendly Hospital Steering Committee

Introduction:
Over the next three years, Sunnybrook Health Sciences Centre will be inventing the future of health care through a new initiative and a commitment to incorporating senior friendly care, hospital-wide. Sunnybrook has a distinguished history of caring for the elderly and is at the forefront of providing a number of specialized programs to meet the needs of our senior population.

To launch this initiative, the inaugural Senior Friendly Hospital Forum was held on June 8th with more than 60 Sunnybrook leaders and health professionals. The day-long forum included a keynote address by Dr. Christopher Patterson, Professor of Medicine in the Division of Geriatric Medicine at McMaster University and the Chief of Geriatric Services at Hamilton Health Sciences Centre. The objectives of the event were to define the culture of a senior friendly hospital; identify the current status of senior friendly care; develop and understand the provincial senior friendly framework; appreciate seniors’ perceptions of their care; and identify patient-centred goals to improve senior friendly care at Sunnybrook.

A survey of staff perceptions of Sunnybrook’s current senior friendly activities identified strengths and opportunities, as well as perceived weaknesses and barriers. Building upon these findings, the forum participants identified three priority initiatives in each of the five domains of the senior friendly framework. The groups worked to define a goal and at least two monitoring indicators for each priority.

Going Forward:
“These initiatives and all the other senior-friendly practices in place at Sunnybrook along with a breadth of new practices need to be shared and woven into the entire tapestry of Sunnybrook,” says Dr. VanDeVelde-Coke, EVP, Chief Health Professionals & Chief Nursing Executive.

A Steering Committee comprised of senior leaders across Sunnybrook and the Regional Geriatric Program of Toronto will be providing leadership and strategic direction to identify, plan, implement and sustain activities and actions to transform Sunnybrook into a senior friendly organization. To ensure that Sunnybrook continues to lead in creating and sustaining senior friendly practices, the Steering Committee will be working on the following key objectives over the next three years:

1. Develop the Senior Friendly Care strategic plan that will guide Senior Friendly initiatives over the next 3 years.
2. Develop, implement and monitor initiatives that will increase organizational capacity and responsiveness to care of seniors.
3. Facilitate, monitor, evaluate and sustain senior friendly initiatives
4. Develop a coordinated communication plan for internal and external stakeholders.
5. Liaise with key external stakeholders and organizations to ensure alignment of Sunnybrook Senior Friendly Care initiatives.

13. Nurse Practitioner Practice in Specialized Geriatric Services

Authors: Laurie Bernick and Eileen Bourret
Trillium Health Centre

The authors describe their scope of practice as nurse practitioners within the Seniors’ Health program at Trillium Health Centre. Each nurse practitioner has a primary area of practice - an ambulatory clinic or an outreach service. A sample of the patients seen by the NPs from January 1 to December 31, 2008 is described. The types of clinical impressions and recommendations made by the NPs during consultation visits, is identified. Ways in which the clinical practice of the NPs is integrated are highlighted. Reflective learning will be highlighted as a way of enhancing the nurse practitioners’ scope of practice.

14. Post-fall Assessment & Management in Persons with Dementia

Authors: Sylvia Davidson, Wanda Kiersnowski, Toronto Rehab Institute

Falls and injuries related to falls are a major health care concern and older adults with impaired cognition are known to be at increased risk of falling. “Stop Adverse Fall Events” (SAFE), an organization-wide fall prevention and management program at Toronto Rehabilitation Institute, was launched over a year ago. In addition to standardized assessment of falls risk and interprofessional discussion of fall prevention strategies, the SAFE program also addresses post-fall assessment and management.

While post-fall assessment is a crucial component of fall prevention and management, it can present unique challenges in older adults with dementia. Risk of morbidity and mortality post-fall increases with age while the ability to conduct a full assessment may be compromised by an individual’s agitation, falls may be unwitnessed and self-reports of injury or distress may be unreliable.
In response to the identified needs of staff on the psychogeriatric assessment unit at Toronto Rehabilitation Institute, a post-fall education session was developed. This poster will highlight the key components of immediate post-fall assessment and decision-making for staff working with persons with dementia, as well as post-fall documentation and methods of interprofessional communication. Plans for sustainability will also be presented.

15. System Transformation in the Care of Homebound Senior: Building Capacity in Geriatric Outreach Expertise

**Authors:** Sheila Simmons, Beatrise Edelstein, Susan Steels

North York General Hospital and Southlake Regional Health Centre

An increasing number of seniors are facing complex health challenges that may prevent them from aging at home safely. The emergence of rapidly changing demographics, financial constraints, and increased rates of chronic illness have contributed to the need for interdisciplinary teams with specialized geriatric expertise to identify, assess and mitigate geriatric risk factors, as well as connect seniors to appropriate services in the community.

Over the past year, the NYGH Geriatric Clinician/Educator, the Geriatric Medicine Outreach team and the Southlake Regional Geriatric Clinician/Educator have been engaged in educational and mentorship activities with the newly formed Geriatric Medicine Outreach Teams in the Central LHIN. With the support from the RGP, they developed, coordinated and delivered didactic curriculum that emphasized core competencies required within a specialized geriatric team. In addition, the new teams were provided with shadowing opportunities and ongoing education, learning needs assessment and mentorship.

The purpose of this presentation is to discuss the implementation of the AAH Geriatric Outreach Teams initiative together with challenges encountered and lessons learned. Furthermore, strategies used to promote system transformation, enhance knowledge brokering, and sustain practice through capacity building, integration of core competencies, and mentorship will be highlighted.


**Authors:** Jennifer Ireland and Sylvia Davidson

Toronto Rehab Institute

The Person-Environment-Occupation (PEO) Model is a systematic framework used extensively by occupational therapists to structure assessment and intervention planning. This model explains the dynamic and interwoven relationships between individuals, their environments, and the activities in which they participate. Enhanced occupational performance is achieved when the three PEO domains are modified appropriately to meet an individual’s unique needs.

The Alzheimer Society of Ontario reports that 70% of older adults living in Ontario long term care (LTC) homes have some type of dementia; and for every one of these individuals, approximately ten others are directly impacted. Challenging behaviours such as repetition, wandering, hoarding, aggression, screaming, incontinence and sleeplessness have a significant impact on an individual’s ability to participate in meaningful self-care and leisure occupations, as well as the LTC homes’ ability to effectively and safely care for their residents.

The Geriatric Psychiatry Service at the Toronto Rehabilitation Institute provides comprehensive, inter-professional assessments of such older adults. Through team collaboration, unique and individualized accommodations are implemented to manage behaviours that are detrimental to the individual’s participation in activities of daily living. With successful accommodations, the challenging behaviours will be reduced, staff and families will be able to provide enhanced quality of care, and the individuals with dementia will experience improved quality of life.

This poster will illustrate application of the PEO Model in dementia care. As well, recent case examples will be presented to demonstrate how the framework is utilized by this specialized assessment unit to develop appropriate strategies for management of challenging behaviours.
Fall prevention is an important intervention for older adults. Each year, one of three seniors will fall and that 50% of these individuals will suffer significant injury. Evidence supports prevention of falls through multi-factorial risk assessment and management programs.

An interprofessional team developed a collaborative pilot research study conducted in a retirement home and an outpatient hospital setting to measure the effectiveness of a falls prevention program to improve physical function and balance, and reduce the fear of falling in older adults who have fallen.

Forty-one English-speaking adults ≥ 65 years of age who had fallen were recruited. Program format included an interprofessional assessment followed by a 12 once a week group education and exercise, and individual counselling. To measure program effectiveness, the Berg Balance Scale, the Timed up and Go Test, the Falls Efficacy Scale and the Morse Fall Risk Scale were used at baseline, upon program completion, and at 3- and 6-months follow-up. Persistent improvements were found in participants’ balance, strength, functional mobility and fear of falling. Patient satisfaction with the program was high.

The next step is to validate the effectiveness of this program by delivering the program in Chinese speaking seniors by utilizing interpreters and translated materials.

17. Development, Implementation and Evaluation of an Advance Practice Nurse (APN) Led Inter-professional Falls Prevention Program for Older Adults

**Authors:** Carol Banez, Man Sandra Tully, Petal Samuel, Lina Amaran, Susan Speigel, Anita Kung.

UHN, Toronto Western

Fall prevention is an important intervention for older adults. Each year, one of three seniors will fall and that 50% of these individuals will suffer significant injury. Evidence supports prevention of falls through multi-factorial risk assessment and management programs.

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The next step is to validate the effectiveness of this program by delivering the program in Chinese speaking seniors by utilizing interpreters and translated materials.

18. Geriatric Emergency Management Model: Where Do We Go From Here

**Authors:** Clara Tsang, Heather Reid, Cathy Steele, Kesavi Mummaneni, Rouge Valley Health System & Breeda Saravanamuttu, CCAC Hospital Case Manager.

**Objectives:**
1. Demonstrate a successful innovative care model for seniors in the Emergency Department (ED) and how this impacts the current system.
2. Describe the development of an inter-sectoral collaboration and coordination to enhance the care for seniors in the health care system

**Description:** The Ministry of Health and Long Term Care (MOHLTC) has recognized the need to improve care for seniors in the emergency department (ED) with the introduction of the Geriatric Emergency Management (GEM) initiative in 2004. This program has enabled GEM nurses and ED staff to engage in ideas that enhance the knowledge and improvement of geriatric care.

This model of care, specific to elderly in the ED, is making a difference in seniors care. The GEM role encompasses direct clinical care with patients and families, facilitates collaboration and coordination with interdisciplinary team members in the development and implementation of individual care, capacity building with internal and external stakeholders, and assists in advocacy for system or policy changes.

The success of this initiative has been illustrated by the expansion of the GEM role in all Local Health Integrated Networks since 2006. Starting with 8 nurses, the program now has more than 50 full time dedicated GEM nurses. The impact of this model is not only demonstrated by the expansion of GEM program but further development of outreach teams to long-term care homes and communities for seniors care.

This presentation will discuss and describe the advocacy and action developed from the GEM model that led to transformational healthcare change. However, one role cannot sustain the movement. The exploration of strategies such as inter-sectoral and interdisciplinary collaboration is crucial in the development of a comprehensive innovative senior care framework and care delivery model for seniors.

**Conclusion:** A change of system and policy in senior care at acute care hospitals, long-term care homes, and communities has been initiated since the implementation of the GEM program. This presentation will describe the impact of the GEM program on the system.

Discussion on the transformational changes and strategies to sustain and support this comprehensive innovative senior care model will provide insight into future developments of senior health care.

19. The Acute Care of the Elderly Unit (ACE) at St. Michael's Hospital after six months: patient population and outcomes

**Authors:** Rola Moghabghab, Maria Zorzitto, Penny Ascroft, Helen Harrison, Dorothy Knights, Kathy Marley, Joanna Stanley, Anne Stephens, Lisa Vandewater.

St. Michael’s Hospital, Toronto, Ontario

The Geriatric beds at St. Michael's Hospital were redesigned as ACE beds in October 2008 with a focus on acutely ill elderly patients. An evaluation of the ACE units six months post-implementation was approved by the Research Ethics Board. A chart review of all patients (N=52) admitted to the ACE unit between October 2008 and March 2009 was conducted. Information collected included demographics, discharge destination, co-morbidities, geriatric syndromes, length of stay, cognitive status and functional status.
Results showed that ACE unit patients had multiple co-morbidities, complex geriatric syndromes and advanced age. 42% were referred directly from the Emergency Department and 58% within 48 hours of admission to Internal Medicine. The majority of the ACE unit patients returned home with an improvement in functional status.

20. Geriatric Emergency Management-Falls Intervention Team (GEM-FIT): The results of an innovative falls prevention partnership

Authors: R Moghabghab, A Stephens, P Thomas, C Acton, M Gruneir, A Merrett, C Goddard, and C Ward
St. Michael’s Hospital

Falls account for the majority of injury-related emergency department (ED) visits in older adults. The aim of this study was to evaluate an evidence-based community falls prevention model for older adults using St. Michael’s Hospital ED. METHODS: We conducted a pre-post intervention design. Data on balance, number of falls, mobility and fall risk factors was collected before, after and six months after a three month intervention period of a series of home visits by public health nurses and occupational therapists.

RESULTS: The project received 22 referrals between July 23, 2008 and March 31, 2008. Nine participants completed the intervention component. Improvements were demonstrated between the pre and post intervention balance, mobility, number of falls and social integration. The average number of risk factors was reduced by 1.64. Modifiable risk factors were reduced for most of the participants including environmental hazard reduction, improved social participation and reduced fear of falling. CONCLUSIONS: Although this study was small, the data demonstrates the effectiveness of collaboration between community and acute care service providers for falls prevention, and the recruitment challenges of seniors presenting to a downtown hospital ED. Recommendations are made for future seniors’ falls prevention initiatives between hospital and community partners.

21. WISE Wellness for Independent Seniors

Author: Kinga Balogh
Women’s College Hospital

As the population ages, more seniors are living independently in the community. WISE aims to help seniors obtain information about health and wellness, link to community and support services, and cope with the changes associated with aging. The goal of the WISE program is to optimize the quality of life for seniors living in the community.

WISE stands for Wellness for Independent SEniors.
- **Wellness** - WISE focuses on the goals of health and wellness for seniors.
- **Independent** - All adults over the age of 60, who live independently in the community, are eligible to participate in the WISE program.
- **SEniors**

Mission Statement:
Promoting the health and wellness of older adults living independently in the community.

The WISE team is a multidisciplinary team made up of the following health professionals:
- Dietitian
- Occupational therapist
- Physiotherapist
- Social worker

Our program aims to:
- Provide support and counseling to older adults and their families
- Offer suggestions to improve our clients’ physical and mental health
- Educate seniors about community resources and healthy lifestyle choices
- Help seniors and their families plan for future care-related needs

WISE offers the following services:
- One-to-one assessment and consultation by the multidisciplinary team
- A community health-and-wellness group that offers interactive workshops. The workshops will be facilitated by a representative of each health discipline involved in the WISE team
- Counselling to help caregivers cope with the challenges they face providing care
- Referral to more specialized services for medical and mental health support

How WISE Works:
- The WISE Team at Women’s College Hospital assesses each client.
- We make recommendations to the client during a follow-up visit. These recommendations are based on goals identified in collaboration with the client, his or her family and the WISE team.
- We provide each client’s family doctor with a formal report. This report includes the results of any assessments and the recommendations from the WISE Team.

Eligibility
You are eligible to participate in the WISE program if you are **60 years** of age or older, and experiencing changes in your ability to function, due to:
- Recent falls/Mobility problems
- Changes in memory/Cognitive Impairment
- Nutritional concerns (such as sudden weight loss or restricted diets)
- Activities of daily living
- Possible elder abuse or neglect
- Alcohol and other Substance Abuse
- Social isolation

*Note: The text has been indexed for better readability and comprehension.*
• Inadequate family or community social supports
• Difficulty with current living situation
• Home safety
• Mental health concerns
• Wandering
• Caregiver burden

Referral
You must be referred to the WISE program by a physician. Self-referrals are also accepted and WISE will coordinate with your physician.

Contact Info
Phone: (416) 323-6400 ext. 8092

22. The Flo Collaborative: Quality Transitions for better Care to Improve the Flow of Patients from Mount Sinai Hospital to Toronto Rehabilitation Institute

Authors: Shanon Bunagan, Evelyne Durocher, Hyacinth Elliott, Carol Holmes, Anita Low, Carmelina Marziliano, Tammy Pulfer, Hazel Sebastian, Sarah Sharpe, Angela Wong

Toronto Rehab Institute

Ensuring timely access to acute care services is a complex issue in Ontario’s health care system and impacts wait times, clinical outcomes and efficiency. Reducing Alternate Level of Care (ALC) days is an immediate strategic priority in the province. Rehabilitation hospitals have a critical role in improving the efficient and effective flow of patients through the health care system as rehab services comprise care destinations for patients transitioning from acute care hospital services.

From September 2007 to January 2009 Mount Sinai Hospital (MSH) and Toronto Rehabilitation Institute (Toronto Rehab) were partners in the Flo Collaborative, a provincial quality improvement initiative. The overall aim of the MSH/Toronto Rehab partnership was to improve the flow of patients from MSH’s three general internal medical units (GIM) to Toronto Rehab’s geriatric rehab unit (GRU).

This purpose of this poster presentation is to describe the partnership’s project aim, sub-aims, changes implemented, results, including both process and outcome measures, important lessons learned through the project and plans undertaken to sustain the gains.

23. The Continuum of Specialized Geriatric Services at Sunnybrook Health Sciences Centre

Authors: Janna Di Pinto, Catherine Bald, Ingrid Otten, Betty Matheson, Rajin Mehta, Mireille Norris, Barbara Liu.

Sunnybrook Health Sciences Centre and RGP Toronto

Sunnybrook is one of the original founding members of the RGP network. The Specialized Geriatric Services at Sunnybrook provide services to seniors that cover the full continuum of care from the Emergency Department, inpatient acute care, outpatient clinics, day hospital and outreach. This is a unique spectrum of service provision not found in any other affiliated teaching hospital at the University of Toronto. This poster describes the services provided to frail seniors through the specialized geriatric services at Sunnybrook Health Sciences Centre. It highlights the scope and impact of our services. In recognition of the value of our services, SGS team members have received prestigious honours and awards. We host students seeking excellence in educational opportunities from around the world. In collaboration with the RGP, the specialized geriatric services at Sunnybrook are a unique resource poised to support the needs of frail seniors and the organization as Sunnybrook embarks on a senior friendly hospital transformation.