

Acute Care of the Elderly (ACE) Program: Newfoundland and Labrador Health Services

Fall 2025



**NL Health
Services**



Healthcare Excellence Canada would like to formally acknowledge Newfoundland and Labrador Health Services' generosity in sharing their skills, knowledge, expertise and experiences to inform this promising practice.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners across the country to shape a future where everyone in Canada has safe and high-quality healthcare. We bring together people, evidence and action to move Care Forward - spreading and scaling quality and safety improvements, strengthening capacity and collective leadership and catalyzing change in policy and practice.

At HEC, healthcare excellence means improving safety, quality and value for everyone. It means care grounded in what matters most to patients, caregivers, communities and people in the workforce. It also means care that respects and responds to First Nations, Inuit and Métis priorities and is culturally safe, equitable and supported by the appropriate use of technology. Together with our partners, we embed these foundations across the health system.

Our work also focuses on expanding access to safe, connected, high-quality care closer to home and community. This includes supporting people with primary health care needs and older adults with health and social needs.

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Enabling Aging in Place collaborative

The Enabling Aging in Place collaborative brought together health and social service organizations from across the healthcare continuum to implement promising practices that can delay people's entry into long-term care. The collaborative aimed to improve safety, health and quality-of-life outcomes, while also reducing emergency department visits, lessening demands on care partners and making better use of health and social care resources.

Teams from communities across the country participated in the Enabling Aging in Place collaborative.



Acute Care of the Elderly (ACE) Units and Model of Care

The Acute Care of the Elderly (ACE) model in Newfoundland and Labrador provides older adults admitted to hospital with specialized care for acute medical conditions, frailty and age-related issues. ACE units are designed to provide person-centred care with integrated clinical support and care pathways tailored specifically for older adults. This care is provided by an interdisciplinary team and can decrease length of stay, prevent deconditioning and social isolation, enhance older adults' ability to safely return home and minimize readmissions.

Evaluations of ACE units show reductions in falls, pressure ulcers and delirium risk, and decreased functional decline post-discharge.^{1,2}

¹ Palmer RM. The Acute Care for Elders Unit Model of Care. *Geriatrics (Basel, Switzerland)*. 2018;3(3), 59. <https://doi.org/10.3390/geriatrics3030059>
² Sinha S, Foster N. ACEING THE CARE OF OLDER ADULTS IN HOSPITALS THROUGH

Newfoundland and Labrador Health Services (NLHS) successfully launched their first ACE Unit at Western Memorial Regional Hospital in June 2024 and their second ACE Unit at St. Clare's Mercy Hospital in June 2025. NLHS began its journey through coaching sessions with Mount Sinai Hospital to learn about the model of care and then adapted it to their own context through their Health of Older Adults Strategic Health Network and Provincial ACE working group.

Key Features

Objectives

The objectives of the ACE model of care include:

- enabling patients to return to the community upon discharge
- identifying frailty in acute care settings
- reducing patient length of stay
- preventing deconditioning
- reducing falls, pressure ulcers and delirium risk for patients
- preventing functional decline post-discharge
- preventing social isolation
- minimizing readmissions to acute care

INNOVATIVE MODELS OF ACUTE CARE FOR ELDERLY. *Innovation in Aging*. 2017;1(Suppl 1), 1346–1347.
<https://doi.org/10.1093/geroni/igx004.4943>

Population served

An ACE approach is designed for older adults admitted to acute care, particularly individuals aged 65 and older living in the community who present with an acute medical condition and have:

- a recent decline in functional abilities
- a recent change in cognition or behaviour
- and a presence or at risk for geriatric syndromes (e.g. falls or mobility changes, incontinence, delirium)

Patients are primarily identified in the emergency department using the Identification of Seniors at Risk (ISAR) screening tool. Patients who have been identified as candidates for an ACE approach are then assessed using tools such as the Clinical Frailty Scale and Comprehensive Geriatric Assessments to determine eligibility for the unit.

Team

The ACE unit has an interdisciplinary care team consisting of nurses, geriatricians, physiotherapists, occupational therapists, social workers, recreation therapists and other providers. A senior-friendly Manager also supports implementation, using resources and training to support the team in delivering age-friendly care. This team collaborates to address the physical, cognitive and social needs of older adults.

The broader adaptation and implementation of the ACE model of care is supported by the Strategic Health Network of Older Adults team. This team provides change management, evaluation and quality improvement support to enable successful implementation of the ACE model of care.

Philosophy

What separates ACE care from traditional acute care is its emphasis on maintaining and reconditioning cognitive and physical abilities while treating acute conditions. Hospitalization of older adults can lead to significant and accelerated cognitive and functional decline.³ The ACE approach incorporates early interventions and other services to help prevent these declines during admission,⁴ increase the likelihood that older adults can return home and delay or avoid institutional care.

ACE unit care

Older adults referred to ACE units receive specialized, patient-centred care tailored specifically to address the complex health challenges faced by older adults. This care includes:

- **Rehabilitation services** – focusing on enhancing mobility, strength and functional independence. This includes physical therapy and occupational therapy.

³ Dasgupta M. Cognitive Impairment in Hospitalized Seniors. *Geriatrics (Basel, Switzerland)*. 2016;1(1), 4. <https://doi.org/10.3390/geriatrics1010004>

⁴ Wong, Roger. Leading best practice: Acute care for elders units – evidence and keys to successful

operation. *Canadian Geriatrics Society Journal of CME*. 2017;7.

- **Medication management** – optimizing medication regimens, which ensures that older adults receive appropriate medications and dosages while minimizing the risk of adverse drug events.
- **Cognitive and emotional support** – providing appropriate support for cognitive impairments and managing mental health concerns.
- **Falls prevention support** – minimizing the risk of falls and providing education and programming on prevention.
- **Social engagement** – reducing the risk of social isolation through activities and programs that promote connection.
- **Enhanced early discharge planning** – supporting smoother transitions home and reducing length of hospital stay.
- **Education and support for care partners** – helping family members and care partners better understand the care needs of older adults and how to assist them effectively.

ACE units include age-friendly considerations in their built environment. For example, to support early mobilization protocols, they have installed handrails, appropriate lighting and non-glare floors, and have provided supportive mobility aids to encourage older adults to begin moving as soon as possible. Similarly, to support adequate hydration, the units include hydration stations and hydration carts to allow older adults to access refreshments independently.



Hospital to home

Ensuring a seamless, safe transition from hospital to home with appropriate continuity of care is a priority within the ACE model of care. An ACE unit plays a pivotal role in improving access to social and community support for older adults by using a holistic approach to healthcare that focuses on the determinants of health. By integrating social workers, case managers and other support professionals into the care team, ACE units can identify and address the unique social challenges faced by older adults, such as isolation, housing issues and caregiver support.

Through Comprehensive Geriatric Assessments and tailored interventions, The ACE model strengthens connections with community resources and social support networks, promoting a seamless transition from hospital to home. This emphasis on planned and managed care transitions with clear communication ensures older adults have access to the necessary social and community support for sustained well-being.

ACE units incorporate family and care partner input throughout an older adult's stay and prioritize their involvement in discharge planning, recognizing their crucial role in providing ongoing support.

ACE model of care and provincial spread

The implementation of the ACE model of care is being led by the Provincial ACE Working Group, which includes representatives from the interdisciplinary teams at the hospitals implementing ACE units. This group adapted ACE best practices to Newfoundland and Labrador's unique healthcare landscape. Provincial zone-based planning events were held to provide regional perspectives on the current state, readiness to move forward with ACE initiatives, and to identify assets, challenges and opportunities for improvement. Insights from these planning sessions and other engagement activities were integrated into discussions at the Provincial ACE Working Group and Health of Older Adults Strategic Health Network to support planning. Working groups were established to determine how to operationalize these strategies, leading to key milestones such as:

- standardized eligibility criteria for ACE units
- development of ACE patient order sets
- enhanced education and training for ACE staff
- creation of an electronic interdisciplinary comprehensive geriatric assessment and interdisciplinary daily rounding tool

The Health of Older Adults Strategic Health Network brings senior directors of acute and community care, clinical leads in older adult care and other interest holders from the provincial health zones together to collaborate on opportunities to improve health outcomes for older adults. The Network supports the implementation of the ACE model of care and other initiatives through oversight, resource allocation and support for advancing changes

to senior leadership. The Network also supports the sharing of learnings from across Newfoundland and Labrador and meets zones where they are in their readiness to implement the ACE model of care and age-friendly care.

In addition to providing dedicated ACE units, NLHS is implementing age-friendly care across all provincial health zones. They are operationalizing this through education and supportive care pathways that can be implemented even without specialized geriatric services.

Implementation context

While formal ACE units are not achievable in all acute care settings because of the required specialized resources (e.g. access to geriatricians), an ACE approach to care can be implemented in many acute care settings. This is achieved through a combination of education and the development of care pathways and processes that align with the specific needs of older adults, including complex health challenges.

In addition to the two ACE units NLHS has opened, they are working to spread an ACE approach to care across the health system to improve care for older adults. A primary enabler of this work was the support of the Health of Older Adults Strategic Health Network, the Provincial ACE Working Group and its partnership with Mount Sinai Hospital. Mount Sinai provided knowledge and guidance based on its extensive experience implementing and sustaining the model, while the Health of Older Adults Strategic Health Network and the Provincial ACE Working Group adapted the model to the Newfoundland and Labrador context using a continuous quality improvement approach.

Outcomes⁵

To date, the following outcomes have been measured.

Improved ability to age in place and return to community

Seventy-eight percent of ACE patients were able to return to the community upon discharge. Almost 89 percent were discharged with supports established during their time on the ACE unit.

The high proportion of patients discharged to the community, most with supports such as home care, demonstrates the ACE unit's effectiveness in facilitating safe transitions and promoting aging in place.

"I was always an independent person, and I'm still an independent person. I had a health issue and they helped me to feel well so I could get back to my life."

– ACE patient

At follow-up, 65 percent of patients interviewed said their ACE care team directly impacted their ability to return to the community. Many credited this to their ACE team's role in supporting their recovery and helping them regain their strength.

"If it wasn't for the good care that I received in that hospital, I wouldn't have been able to get home. The doctors and the nurses there were excellent."

– ACE patient

Improved quality of life

Eighty-five percent of patients said in a follow-up survey that ACE positively impacted their quality of life one to three months after they left the hospital. Patients highlighted the value of the interdisciplinary approach, including encouragement, mobility support and physiotherapy in improving their quality of life.

"They helped me regain my strength when I was sick and get back on my feet."

– ACE patient

Seventy-one percent said the referrals they received positively impacted their current quality of life. Referrals to community services extended benefits beyond the hospital stay and connected patients to supports that help maintain their independence.

⁵ The outcome and impact information shared reflects information available at the time of writing this promising practice. HEC would like to acknowledge that evaluation activities are an ongoing process for many promising practices and

the type of data collected is influenced by program goals, the length of time the program has been implemented and the level of resources available to support evaluation.

“Oh yes, my love, they helped me with everything. They helped set me up with homecare. When I went in the hospital, I couldn’t walk well. They helped me get around with my walker. They were really good to me.”

– ACE patient

Improving provider experience through interdisciplinary care

ACE units rely on interdisciplinary collaboration, which enables providers to learn from and support each other. ACE unit staff rated the effectiveness of the interdisciplinary daily rounding process as 8.4/10.

Working in an interdisciplinary team and participating in daily rounds enhanced staff capacity in age-friendly care by promoting collaboration, shared decision-making and proactive identification of patient needs.

Staff reported that the range of expertise and skill sets allowed the team to distribute responsibilities effectively, ensuring each patient received more thorough and coordinated support. Daily rounds also created practical learning opportunities across disciplines, streamlined care planning and focused discussions on factors that impact care outcomes for older adults.

“It’s truly a gift to have a team as dedicated as this. We round every day and exchange information in a seamless way. Having a multidisciplinary approach has made it a lot faster to collect information, implement change, and support discharge planning.”

– ACE unit staff member

Funding

ACE units operate with committed operational funding from Newfoundland and Labrador Health Services to support staffing, resources and implementation of the ACE model.

Partnerships

A primary objective of ACE units is to support older adults to return to the community upon discharge from acute care. This requires strong connections and partnerships with community supports to ensure an effective transition of care. NLHS ACE units have built strong connections with Community Support Programs, including the Home Support Program, which provides personal and behavioural supports, household management and respite to maintain individual independence. As well as the Special Assistance Program, which provides basic medical supplies and equipment to assist with activities of daily living for individuals living in the community who meet the eligibility criteria.

ACE units also establish partnerships with primary care and family care teams to ensure seamless communication among healthcare providers, coordinate services and facilitate smooth transitions from hospital to home.

The senior-friendly Manager builds connections to community partners, including maintaining lists of community supports and services so they can connect older adults transitioning home from an ACE unit. They also work with Seniors NL and the Link Workers program through their social prescribing program to support connections to community-based supports.

These partnerships help older adults and care partners transition home from acute care safely and continue to receive appropriate formal supports in their communities.

This promising practice was co-produced with Newfoundland and Labrador Health Services. Information was compiled in the fall of 2025. In keeping with the changing and evolving nature of care, the information may change in the future. We encourage you to reach out to this team for any further information that may be helpful as you work to improve care for those you serve.

How can I learn more?

www.nlhealthservices.ca