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National Clinical Programme For Older People

OLDER PEOPLE

Specialist Geriatric Services Model of Care

Part 1: Acute Service Provision

July 2012

Seirbhís Sláinte Náisiúnta
Health Service Executive

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

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Foreword

This model of care for Specialist Geriatric Services was initiated in 2010 through the National Clinical Programme for Older People Working Group and RCPI/ Irish Society of Physicians in Geriatric Medicine Clinical Advisory Group.

This document is Part 1, version 1 of a Specialist Geriatric Services model of care and describes the structures and patient management for the acute inpatient, acute rehabilitation, day hospital, outreach and ambulatory services provided by Specialist Geriatric Services/ Teams which are acute hospital based.

A community, primary care and general practice Model of Care for services for the frail older person is under development and will be consolidated with this component of the Specialist Geriatric Service Model on its completion. The timeline for this is end of Q4 2012.

Abbreviations

AMU	Acute medical unit
CGA	Comprehensive geriatric assessment
CSP	Clinical Strategy and Programmes
DH	Day hospital
ED	Emergency department
ICT	Information and communications technology
H&SCP	Health and Social Care Professional
MDT	Multidisciplinary team
NCPOP	National Clinical Programme for Older People
NSP	National Service Plan
OPD	Outpatient Department
OT	Occupational Therapist
SGS	Specialist geriatric services
SGT	Specialist geriatric team
SGW	Specialist geriatric ward
SLT	Speech and Language Therapist

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1 Executive Summary

The National Clinical Programme for Older People (NCPOP) is a joint initiative between the Directorate of Clinical Strategy and Progammes (CSP) of the Health Services Executive (HSE) and the Royal College of Physicians of Ireland (RCPI). It is a health services response to the increasing numbers and special needs of older people who present to acute hospitals. This initiative/document sits within the overall context of the development of comprehensive, integrated and patient focused services for older people. It is one of a series of initiatives to provide a continuum of health and care services for older people.

We can expect those over 65 years of age to increase from 11.4% currently to 18% of the population over the next 30 years. It is expected that those over 85 years of age will increase by 150% by 2031. Those over 75 years of age and especially those over 85 years of age have the poorest health and the greatest disability.

The concept of frailty, a current area of research focus, is associated with key clinical syndromes that are well recognised by geriatricians. These include loss of mobility, falls, confusion, incontinence and polypharmacy. The prevalence of frailty depends on the definition used and the population studied. In her original Cardiovascular Health Study, Fried established an overall community prevalence of frailty of 6.9%. SHARE-FI across 12 European countries, found a community prevalence of 4.3% (Romero-Ortuno, O"Shea, Kenny 2011). Thus it would be prudent to estimate an overall prevalence of frailty in the community between 4 and 7%.

In the hospital, prevalence has not been so well studied. The problem with applying Fried's definition of frailty is that walking speed, exhaustion and low muscle strength are influenced whilst people are 'off their baseline' due to acute illness. However, people have estimated prevalence between 20 - 50%. In specialist geriatric wards this could easily reach 80%.

Whatever number one selects there is clear evidence that those showing signs of frailty are at a particular risk of adverse outcomes such as death and institutionalisation and benefit from specific and effective intervention.

It behoves us to plan services and systems to meet this predicted demand.

The care of the frail older person in community settings is complex and comes within the ambit of many different clinical professionals including general practitioners and their staff, primary care, public health/community nurses and health and social care professionals, as well as secondary care clinicians including geriatricians, psycho-geriatricians.

The core care of the frail older person in the community remains the responsibility of the general practitioner and the primary care team.

1.1 Purpose and Scope of the Model

The purpose of this document is to outline a specialist geriatric service, to meet the needs of the frail older person presenting to hospital. As a regular user of acute hospital services, plans that interface with community services need to be in place to meet their needs.

There are a number of key constituents to a comprehensive service including GP care, public health nursing, home care supports, acute hospital care, rehabilitation and long-term care. The ultimate goal is to facilitate the older person to lead an independent life, with dignity, in the community. Therefore the appropriate services must be available to each person when and where required.

The core components for a Specialist Geriatric Service (SGS) in the acute hospital sector include dedicated inpatient wards, on-site and off-site rehabilitation units and rapid access

ambulatory or day hospital (DH) services integrated with community and primary care services. These services are addressed in this model of care. Other components of the service such as outreach services, greater integration with community and primary care services and subspecialty clinics also need to be considered.

Older people and their families expect high quality services that meet their needs in a timely manner. In addition to those based in acute hospitals they expect appropriate services to be provided in community settings. They expect them to be accessible not only in terms of transport to the facility but in terms of domiciliary services in their own homes. Such services need to be capable of promptly and competently responding to the needs of the community they serve.

We set out in this Model of Care (Part I) the principles by which the acute hospital sector can provide high quality care for older people. Part 2 will do likewise for care in the community, including general practice and primary care. How each healthcare area configures and delivers these services may vary.

Comprehensive Geriatric Assessment (CGA) is fundamental to planning services to meet the needs of the older person. As resources are not infinite, the first challenge is to identify those who need to be assessed, where they will be assessed and by whom. Older people with particular syndromes including falls, delirium, dementia, polypharmacy and immobility, or age criteria, may be used to target this patient group. We have identified a number of tools that may aid in identifying those who should be prioritised for assessment in the Emergency Department (ED) and Acute Medical Unit (AMU). Research currently under way to improve the identification of the frail older person is likely to be mainstreamed in clinical practice in the years ahead and may inform patient selection in a different manner. NCPOP will keep abreast of such developments.

Once identified, the person will need an access point from the community to a place of assessment for their CGA. Sites such as the ED, AMU, outpatient department and the DH will all be appropriate for this purpose. Where this assessment takes place will depend on the acuity of the person"s needs and the illness.

This Model of Care describes the pathway for access to and the continuum of care in the acute hospital setting. It also provides details on the structure of the specialist geriatric team (SGT), governance of the service, and the delivery of education and continuing professional development. It sets out key performance indicators to enable services to demonstrate improvements in delivery of person- centred care while maximising return for investment.

We appreciate that much good work is being done in many centres around the country. The main focus of this document is to support this work and provide a template from which we can all deliver the highest standard of care to the frail older person.

Specifically the SGS will:

1. Be based in the acute hospital site, linked to onsite rehabilitation and DH services
2. Allow service reconfiguration of the current team of consultant geriatricians at the hospital to enhance delivery of care to the older adult
3. Provide specialist assessment and treat-ment in acute care settings including EDs, AMUs and rapid access clinics in DHs or OPD
4. Facilitate patient rehabilitation from the time of hospital admission through to discharge to community-based rehabilitation services, through communication systems within and across care settings
5. Provide a DHs as the information and coordination hub for services for frail older people

6. Support primary care services in nursing homes and extended care settings through specialist consultation on request of the General Practitioner or Medical Officer
7. Implement care pathways, guidelines and care bundles to improve quality, efficiency and outcomes
8. Support implementation of advanced care / end of life protocols in association with the palliative care programme
9. Facilitate cross-specialty activity with relevant services e.g. psychiatry for older persons and palliative care services
10. Contribute to planning, evaluation and monitoring of services by maintaining data a register of frail older people and through data collection in respect of performance measures
11. Contribute to education and training programmes for professionals and staff involved in caring for the frail older person
12. Support co-ordination between developments in NCPOP and other clinical programmes and services.

1.2 Programme Recommendations

The Model of Care has set out a number of recommendations for the establishment of a Specialist Geriatric Service and successful delivery of measureable outcomes for frail older people. The recommendations follow the end to end pathway/ patient journey from their home, through primary care, acute care and discharge home (or other).

Pathway Stage	Recommendation
Older person keeping well in the community	Health promotion strategy is implemented to maintain physical and mental health amongst older people, including modifications of the environment, support for community groups, personal education and the contribution of health and social services.
General Practitioner and Primary Care Team	A Model of Care encompassing general practice, primary care and community is developed for the ongoing care and rehabilitation for frail older person incorporating pathways for access and referral to ambulatory and acute Specialist Geriatric Services.
Identifying „Frail Older People" or "at Risk" Patients in ED/AMU	Each ED/AMU in conjunction with the Specialist Geriatric Service will have in place an agreed process for identifying / triaging the frail / at risk older patient.
SGS Role in the ED/ AMU	The Specialist Geriatric Service will link with the ED and AMU when an older person at risk is identified requiring referral to SGS, including for CGA or admission to a specialist geriatric ward.
Referral to the SGT	1. Each SGS will have defined and agreed criteria with their ED, AMU and Community that determines whether a patient should be referred to the SGT. 2. Once referred, decisions about the appropriate SGS to

	meet the patient‟s needs will be made by a senior professional to a specified timeframe.
Comprehensive Geriatric Assessment	All identified older frail patients to have a timely CGA performed and documented in their permanent health record that is accessible to both the primary and secondary care teams.
Specialist Geriatric Ward	Each hospital receiving acutely ill older adults must have a dedicated Specialist Geriatric Ward with appropriate staffing levels and a designated MDT
Inpatient rehabilitation	Each hospital has access to onsite and off-site rehabilitation beds and delivers a structured rehabilitation programme for older people.
Discharge Planning	A systematic approach to discharge planning will be facilitated by admission of the frail older person into an SGW with an SGT. Each hospital to have an SGT, with clear responsibility and processes for CGA, integrated discharge planning, and communication with the patient and professionals in other care settings.
SGS Outpatient and rapid access clinic	Each SGS will provide and outpatient services which encompasses subspecialty clinics with rapid access slots for urgent referrals.
Day Hospital on the acute site	Each hospital receiving acutely ill older adults must have an onsite day hospital capable of meeting the needs of the catchment area population.
Outreach to long term residential care facilities	Each SGS will provide an Outreach service, prioritising patients in long term care referred by the GP or Medical Officer. The Outreach service will also liaise with psychiatry for older persons and support training and education of community based staff.
Working with Community Based Services	The establishment of SGTs in acute hospitals will facilitate communication with GPs and PCTs. A single access point will be established to support referral. Outcome of hospital assessment and care will be communicated in a timely manner to the referral source.
Pathway Enablers	The interRAI single assessment tool should be available to primary and secondary care services to facilitate care of all identified frail older adults

1.3 Structure of the Document

A brief description of the content and purpose of each of the chapters within the model of care for Specialist Geriatric Services is outlined below.

Chapter 1: The Executive Summary aims to introduce, give context, scope, purpose and background to the development of a specialist geriatric service model of care.

Chapter 2: Describes the rationale and evidence base for the model of care.

Chapter 3: Provides a glossary of terms which are used through the document.

Chapter 4: Outlines the functions of a specialist geriatric service and provides a detailed pathway descriptor for the end to end patient journey through specialist geriatric services.

Chapter 5: Outlines the functions of a structured rehabilitation programme for older people as inpatient and introduces non inpatient rehabilitation.

Chapter 6: Talks about the members of the Specialist Geriatric Team and other staff who are involved in providing care of the older person in the acute setting.

Chapter 7: Who is responsible for ensuring that care is delivered in the structured manner addressing the patients care needs? Governance arrangements need to be clear and unambiguous and are addressed in this chapter.

Chapter 8: Age attuning the health care system is the responsibility of all under and post graduate training bodies. The chapter sets out existing models and proposals for ensuring all staff have the appropriate skills when caring for older people.

Chapter 9: The tracking and monitoring of progress of the implementation is key in demonstrating the benefits and clinical outcomes of the model of care. The Key and Performance measures described in this section will be evaluated for sites which adopt the model into their service delivery.

Chapter 10: Provides the comprehensive evidence base and list referenced literature from which the model has been derived.

2 Rationale for the SGS Model of Care

In relation to the care of the frail older person, three up-to-date meta-analyses have identified that specialist geriatric teams (SGTs) improve quality of care and patient outcomes (Baztan et al, 2009, Ahmed and Pearce, 2010, Ellis et al, 2011). The rationale for these benefits is that these specialist teams have the expertise and experience necessary to deal effectively with the older person with complex care needs in the acute setting. This includes integration with community services, improving access to home supports and other resources to enable the person to stay well and at home if possible.

Hospital avoidance for the frail older person is beneficial. Among 70 year olds who are admitted to hospital, 35% show functional loss at time of discharge when compared to pre-hospital admission. This percentage increases to 65% for 90 year olds. While older people are admitted to hospital for medical reasons, by the time their medical condition is stabilised, arrangements for their discharge become dependent on many other issues, including ability to undertake basic self-care, their social circumstances, the availability and access to home-care packages, and nursing home beds. The original reason for admission becomes less important and other issues become centre stage, presenting a dilemma for an acute hospital, where the primary function is dealing with medical needs of patients.

A culture change needs to occur in this regard, as a person with complex needs and an acute illness needs more than the illness addressed. Thus a main focus should be to ensure that key personnel in acute hospitals are up-skilled to manage and aid the recuperation of those with complex care needs. Furthermore, appropriate linkages with community services must be in place early to ensure that appropriate services can be planned and operationalised in a timely manner after the acute phase of the illness or intervention.

3 Glossary / Definitions

Acute medical unit (AMU): An area of the acute hospital where patients suffering from acute medical illnesses are admitted, assessed, treated and then either discharged or transferred for ongoing care to a specialist ward. These are increasingly led by consultants who specialise in acute internal medicine. Well-managed AMUs that include a multi-disciplinary team reduce in-patient mortality and length of stay without affecting re-admission rates.

Acute medicine: That part of general (internal) medicine concerned with the immediate and early specialist management of adult patients suffering from a wide range of medical conditions who present to or from within hospitals, requiring urgent or emergency care.

Clinical Case Manager for Older Persons: The purpose of the case manager role is to implement a model of active case management and care co-ordination with the outcome of ensuring patients and families are facilitated to understand their care and to work in partnership with the MDT and wider communities to ensure the provision of care at home where possible. The case manager will be based in community navigation hub to provide a seamless integrated service with a multidimensional and multidisciplinary input for acutely ill frail older persons as they move through the acute sector and home again. The case manager will manage the throughput of patients in transitional care who are going to long term residential care.

Clinical Governance: is described as a system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered. For health care staff this means: specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do.

Comprehensive Geriatric Assessment (CGA): A multidisciplinary diagnostic process focused on determining a frail older person"s medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long term follow up. This is provided by the SGT.

Day Hospital (DH): The main purpose of the DH is to prolong independent living through specialist assessment and treatment of older people with complex care needs, enabling them to remain in their own homes, as well as having a favourable impact on impairment, disability and handicap. The potential gains for the patient are in function, independence, health, reduced disability and coping with impaired function. The breadth of assessment, rehabilitation and services provided in a DH will vary depending on the setting. Key aspects of day hospital services include:

- The DH is a hub for ambulatory specialist services for older people, supporting integration between hospital and home based services
- It is staffed by a core multidisciplinary team (MDT)
- Out-patient healthcare services include multidisciplinary assessment, treatment and rehabilitation, with attendance for assessment or for day care (full or part-day) by community-based older people
- Integrated assessments of health and care needs are provided, for example associated with chronic disease management programmes in the community or for decisions regarding placement in institutional care
- Rapid access clinics provide CGA to reduce inappropriate admissions and support ongoing care in the community
- The DH functions as a hub for information, education and training for patients, carers and professionals.

Frail older people: Those patients characterised by low physical activity and global weakness, with low muscle strength and reduced functional reserve, presenting with falls, confusion and immobility, and are increasingly challenged to continue to live independently at home.

High Dependency: An increasing number of patients have high levels of dependency and the health services need to establish a bank of extended care inpatient beds to cater for their needs. Patients with high dependency requiring a level of input more analogous to hospital level care include those whose clinical course is complicated by recurring medical problems such as:

- Mechanical / assisted ventilation
- Patients who are unconscious or in a persistent vegetative state
- Congestive cardiac failure requiring frequent specialist input
- Life threatening conditions requiring frequent review e.g. brittle diabetes,
- Patients with dialysis-related issues requiring frequent specialist input
- Patients requiring frequent interventions such as blood transfusion
- Patients with severe behavioural problems requiring frequent specialist psychiatry of old age input.

Long term residential care beds / nursing home beds: The service required to care for a frail older person when their medical, nursing and biopsychosocial needs can no longer be met in their own home. The older person who is considering applying for nursing home placement has a CGA as part of the application process.

Older people: Geriatric medicine is mainly concerned with people over the age of 65.

Rehabilitation: Rehabilitation is a progressive, dynamic, goal-oriented and often time-limited process, which enables an individual with impairment to identify and reach his / her optimum mental, physical, cognitive and social functional level. There are three categories of rehabilitation; general rehabilitation, specialist rehabilitation service and complex specialised rehabilitation services. Older people with medical illnesses lose independence / function and hence recover slowly. Rehabilitation with a specialist MDT for the older person improves functional outcome and increases the likelihood of discharge to home. Core members of the rehabilitation team are the patient, carer, doctor, nurse, physiotherapist, occupational therapist, speech / language, clerical, psychologist, social worker, dietitian. Key functions of the team are assessment, treatment, education, liaison within and without the team, planning and development. *See also Chapter 5, Rehabilitation of the Older Person*

Inpatient rehabilitation for the older person: There are two types – on the acute hospital site and off the acute hospital site. In both settings the geriatrician led MDT input is to maximise a person"s level of independence prior to discharge and advise on, or arrange the discharge plan. It is difficult with the frail older person to fix rigid time intervals for inpatient rehabilitation. It would be reasonable that within 6 weeks on the acute hospital site or within 3 months off-site, that the MDT, patient and family would have a structured review to assess progress, set further goals and effect a discharge plan with community services.

Single Assessment Tool (SAT): Services for Older People are due to implement structured needs assessment nationally following extensive work by the SAT Working Group to consider, select and pilot an assessment tool. The interRAI™ suite of assessment tools has been chosen for pilot testing. These operate on the premise that comprehensive, standardised assessments include an evaluation of functional, psychosocial, and environmental needs. This comprehensiveness is key to planning and delivering high quality of care for individuals. Data captured in these assessment tools can be used by front-line (direct care) staff as well as managers, researchers and policy makers - hence these tools have both clinical and administrative utility.

It is proposed to commence phased implementation, focusing initially on older people who may be seeking support through either the Home Care Package Scheme or the Nursing Home Support Scheme (NHSS / Fair Deal). Any work that the NCPOP may be undertaking should be cognisant of the proposal for national phased implementation of the SAT for older people over the coming years, with interRAI being the selected tool across community and acute care settings initially, and thereafter into long term residential care. Careful liaison will be maintained between Services for Older People and the NCPOP.

Specialist Geriatric Services (SGS): These services are structured and use processes of care designed to maximise quality of care and improve outcomes for older people who are frail or have complex care needs. This Model of Care (Part I) describes acute inpatient, acute rehabilitation, day hospital, outreach and ambulatory SGS provided by specialist teams base in the acute hospital. A community, primary care and general practice Model of Care (Part 2) is under development to and will be consolidated with acute SGS Model when completed.

Specialist Geriatric Teams (SGTs): A recent Cochrane Review concluded that better outcomes result from delivery of specialist geriatric assessment by an SGT which is a geriatrician led multidisciplinary team comprising of medical, nursing, and health and social care professionals assigned exclusively to a specialist geriatric service.

Specialist Geriatric Services Outreach Service Each SGS will provide an Outreach service, prioritising patients in long term care referred by the GP or Medical Officer. The Outreach service will also liaise with psychiatry for older persons and support training and education of community based staff. All patients in long-term care facilities have access to their primary care services, and availability of geriatricians to provide an outreach service if requested by the general practitioner**.**

Specialist Geriatric Wards (SGWs): The Cochrane Review (see SGTs) concluded that better outcomes result from delivery of CGA and inpatient care in geographic defined wards. The median length of stay in a Specialist Geriatric ward is 18 days.

Transitional Beds: Transitional beds are for patients whom the SGT agree have reached a plateau in their rehabilitation programme, have a clear discharge plan and are awaiting long term residential care or those who are waiting home support services. The transitional care beds are case managed by a patient flow case manager. The maximum length of stay in a transitional care bed is 30 days.

4 Specialist Geriatric Services

4.1 Functions of Specialist Geriatric Services

Aim:

The SGS Model of Care aims to improve quality and efficiency of care for older people with complex health care needs and for the frail older person. Part I describes care by specialist teams based in acute hospitals.

Objectives of SGS are:

- To develop and implement specialist multidisciplinary geriatric services, with dedicated specialist in-patient wards, providing CGA, treatment, rehabilitation and discharge planning
- To establish Specialist Geriatric Teams (SGTs) to:
    - Work in EDs, AMUs, rehabilitation units, DHs and OPD
    - Liaise with clinical professionals including general practitioners and their teams, public health / community nursing service, health and social care professionals, secondary care clinicians and psycho-geriatricians
- To act as a specialist resource and provide clinical leadership for the care of all older patients in the hospital, in conjunction with other hospital-based clinical programmes.

Specifically the SGS will:

1. Be based in the acute hospital site, linked to onsite rehabilitation and DH services
2. Allow service reconfiguration of the current team of consultant geriatricians at the hospital to enhance delivery of care to the older adult
3. Provide specialist assessment and treatment in acute care settings including EDs, AMUs and rapid access clinics in DHs or OPD
4. Facilitate patient rehabilitation from the time of hospital admission through to discharge to community-based rehabilitation services, through communication systems within and across care settings
5. Provide a DHs as the information and coordination hub for services for frail older people
6. Support primary care services in nursing homes and extended care settings through specialist consultation on request of the General Practitioner or Medical Officer
7. Implement care pathways, guidelines and care bundles to improve quality, efficiency and outcomes
8. Support implementation of advanced care / end of life protocols in association with the palliative care programme
9. Facilitate cross-specialty activity with relevant services e.g. psychiatry for older persons and palliative care services
10. Contribute to planning, evaluation and monitoring of services by maintaining data a register of frail older people and through data collection in respect of performance measures
11. Contribute to education and training programmes for professionals and staff involved in caring for the frail older person

12. Support co-ordination between developments in NCPOP and other clinical programmes and services.

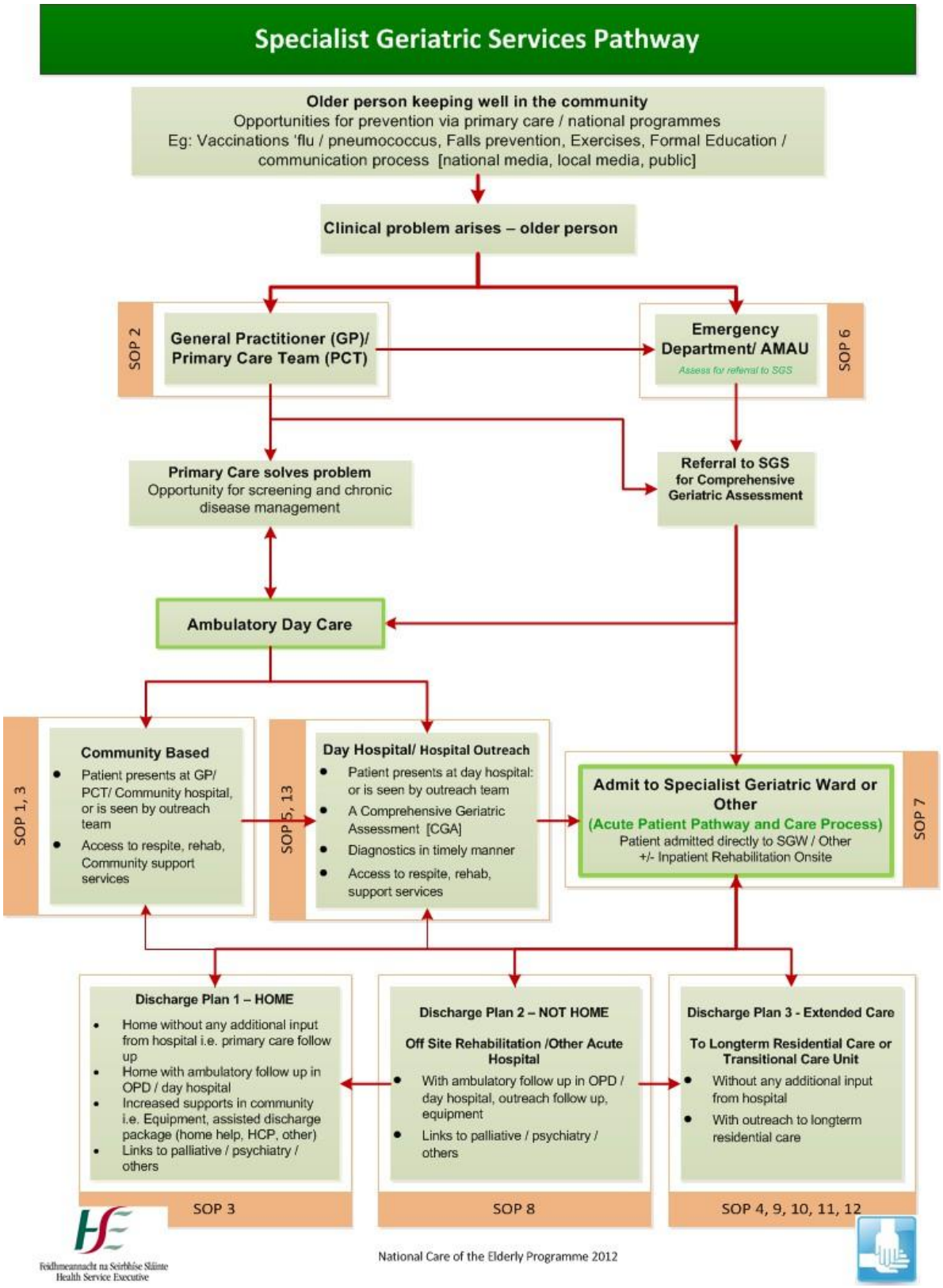
4.2 What the older patient can expect from SGS

The older patient can expect a modern, integrated, resourced service capable of delivering assessment and care in the most appropriate environment to meet their needs. Specifically;

- To be involved in decisions made about their health and future care
- Adequate numbers of appropriately trained staff
- Clear and sensitively expressed explanations of their medical condition, unless their ill health prevents this, and of the treatment options available, in writing if required
- If the older person wishes, this information will be shared with relatives, friends and carers
- That relatives, friends or other advocate may give and receive information on their behalf, if the older person has difficulty in understanding or communicating and gives consent
- Practical advice on appropriate support services and information to enable them to adapt to illness and disability
- Written information on local health and social services, welfare benefits and voluntary organisations
- That support will also be available to their family and significant friends
- Access to their health records and the security of knowing that everyone in the health care system is under a legal obligation to keep records confidential
- Health premises to be accessible to people with disability

4.3 Specialist Geriatric Service Pathway

This Model of Care sets out to describe the acute pathway for frail older people and how specialist geriatric services can deliver the appropriate care in the most appropriate setting. The pathway below illustrates the frail older persons end-to-end journey from primary care through the acute hospital and ambulatory care.



Although this model is part 1 of Specialist Geriatric Services for Acute Service Provision, it is cognisant that the majority of patients are healthy and living at home and under the care of their general practitioner. Part 2 of the Specialist Geriatric Service Model of Care is under development and will address the Primary, Community and General Practice components of the service. Integration of these sectors is key, hence some components of Part 2 of the SGS Model are outlined below. This work is due to be completed in Q4 2012.

4.4 Acute Patient Pathway and care processes

	Ideal	Current	Action required
ED / AMAU assess for referral to SGS	Triage frail older people to Specialist Geriatric Services (SGS)	Random allocation No process to identify „frail"	Triage process in each acute hospital to identify frail older people e.g. ISAR screening tool, Acute Medicine Toolkit 3 (RCPUK) or other
Inpatient referral to SGS	Identification of older inpatients in the hospital [i.e. medical, surgical, gynae etc] who need Specialist Geriatric Services (SGS)	Random consult process	SGS facilitates education throughout the hospital to enable all teams to identify and refer frail older people to the SGT
Admission	Patient to inpatient SGW CGA Differential diagnosis SGT assessment and action plan Discharge plan generated	Dedicated Specialist Geriatric wards not universally available Specialist geriatrician led team not universally available	Dedicated Geriatric Specialist Ward in each acute hospital Dedicated core SGT in each acute hospital
Intervention	Timely diagnostics Timely access to other specialist services : ▪ Surgery ▪ Orthopedics ▪ Rheumatology ▪ Cardiology ▪ Respiratory ▪ Oncology ▪ Palliative ▪ Psychiatry Rehabilitation plan implemented, progress reviewed at SGT meetings, discussed with patient and / or carer	Delays / duplication Paper based systems – inefficient with inherent delays	Regular SGT meetings Access to designated rehabilitation beds Systematic approach to communicating with the patient and / or carer
Discharge 1	Discharge HOME plan proceeds: Timely access to Home Help, Home Care Package, equipment, primary care	No patient case management in the community to manage the transition of patient	Integrated single assessment, referral and response tracking system and case management role

	services, including PCT or specialist rehabilitation MDT Timely communication to primary care ICT – unique identifier, shared info / electronic chart	from acute to home and track referral to response times.	required.
Discharge 2	Discharge to offsite rehabilitation, another hospital, hospice, respite etc.	Inadequate recording of discharge destination for patient follow-up and service planning.	Destination options suited to NCPOP to be recorded on HIPE Portal e.g. offsite rehab, respite etc. as audit and outcome measurement
Discharge 3	Long term residential care plan proceeds Timely CSAR completion Timely family application Timely access to appropriate LTC	Wait in hospital Funding is rate-limiting step Lack of audit regarding patient outcomes, discharge destination etc.	*Set standard – "95% CSARs to be signed by specialist in geriatric medicine"* Systematic audits Destination options on HIPE Portal e.g. return to nursing home, new to nursing home
Communication	Seamless, accessible by all service providers	No IT structure for capturing SGS pathway, process or outcome data. Current HIPE system does not accurately capture discharge plan or destination of patients to Rehab etc.	Paperless system to be used for referral, dissemination of results, CGA and performance measurement, bed management, coordination of day services etc. SAT for acute and community CGA of frail older patients. See Appendix 7.

4.5 Pathway Descriptors

4.5.1 Older person keeping well in the community

Most older people are living independently in the community without any acute medical problems. Opportunities are being missed to enhance healthy ageing and to prevent disease. This includes, to start with, maintaining function, exercise, falls prevention, medication information, vaccinations, safe travel, bone health, footwear, heat, warmth and nutrition. There is a role for sustained health promotion programmes. The voluntary

sector, national and local media provide opportunities to enhance public awareness and education on key health topics.

Recommendation: Health promotion strategy is implemented to maintain physical and mental health amongst older people, including modifications of the environment, support for community groups, personal education and the contribution of health and social services.

4.5.2 General Practitioner and Primary Care Team

The General Practitioner is central to the coordination of this care. For most frail older people, he or she is the ultimate case manager orchestrating the medical care of the individual on a daily basis and seeking the advice of others with specialist knowledge and skills when needed. This may be through referral to the professions allied to medicine or to other clinical colleagues

A number of challenges need to be addressed in the provision of specialist community services for frail older people.

Recommendation: A Model of Care encompassing general practice, primary care and community is developed for the ongoing care and rehabilitation for frail older person incorporating pathways for access and referral to ambulatory and acute Specialist Geriatric Services.

4.5.3 ED/ AMU Assessment

4.5.3.1 - Identifying „Frail Older People" or "at Risk" Patients in ED/AMU

Many frail older patients attend the ED/AMU for acute medical care. Some of these patients will require a CGA. It can be difficult for routine ED medical work-ups to detect at-risk geriatric patients, as the focus of the assessment is primarily on the presenting complaint, which may in some cases only partially address the concerns of the patient, their family and geriatric medicine.

There is a substantial literature on the identification and characterisation of the frail older person with deteriorating health and at risk of adverse outcomes. Such older people are more likely to have:

- History of admission to hospital within past 3 months
- Delirium /confusion
- Falls and poor mobility
- Functional decline
- Polypharmacy
- General deterioration
- Complex disease management
- Social factors

Research instruments identify the older person requiring more detailed assessment and care planning with a high degree of accuracy. However, such questionnaires are unsuitable for use in routine health services. Consequently screening tools have been developed to identify the frail older person in different settings and for different purposes.

In general they aim to identify patients at risk of adverse health outcomes based on assessment of a number of physical, psychological and social phenomena (McCusker *et al.* 1999). Examples include the SHARE Frailty Instrument for use in primary care which classifies people as non-frail, pre-frail and frail (Romero-Ortuna R, O"Shea D, Kenny RA 2011) and the Clinical Frailty Scale which uses a 7 point scale from „very fit" to „severely frail" on the basis of the level of fitness, presence of disease and dependence on others for activities of daily living (Rockwood et al 2005). These tools are brief, user friendly, economical and an efficient way of detecting frail older patients in need of specialised assessment, treatment and referral.

In the ED / AMU a triage process is required to identify those older people requiring referral to the SGS. Screening tools have been used for this purpose and can be administered by a range of health professionals.

ISAR and similar instruments are not diagnostic tools and their use should not replace clinical evaluation and the judgement of health professionals (Appendix 1). Identified patients should be referred to the SGS in the appropriate setting.

Recommendation: Each ED/AMU in conjunction with the Specialist Geriatric Service should have in place an agreed process for identifying / triaging the frail / at risk older patient.

4.5.3.2 SGS Role in the ED/ AMU

In some locations ED staff will triage those older people requiring SGS in addition to initiating treatment for the presenting complaint. In others, screening may be carried out by a member of the SGT. The Acute Medicine Programme document indicates that a designated space should be assigned within the AMU / AMAU / MAU tailored to meet the needs of an ageing population with more complex illnesses.

A member of the SGT attending the ED or AMU is an effective way of supporting the acute work-up, facilitating case finding for SGS. The strength of this collaboration between the SGT and the ED and AMU is that appropriate referral pathways can be implemented in conjunction with general practice, primary and community care services e.g. to the OPD or DH, or admission for CGA, rehabilitation and care planning.

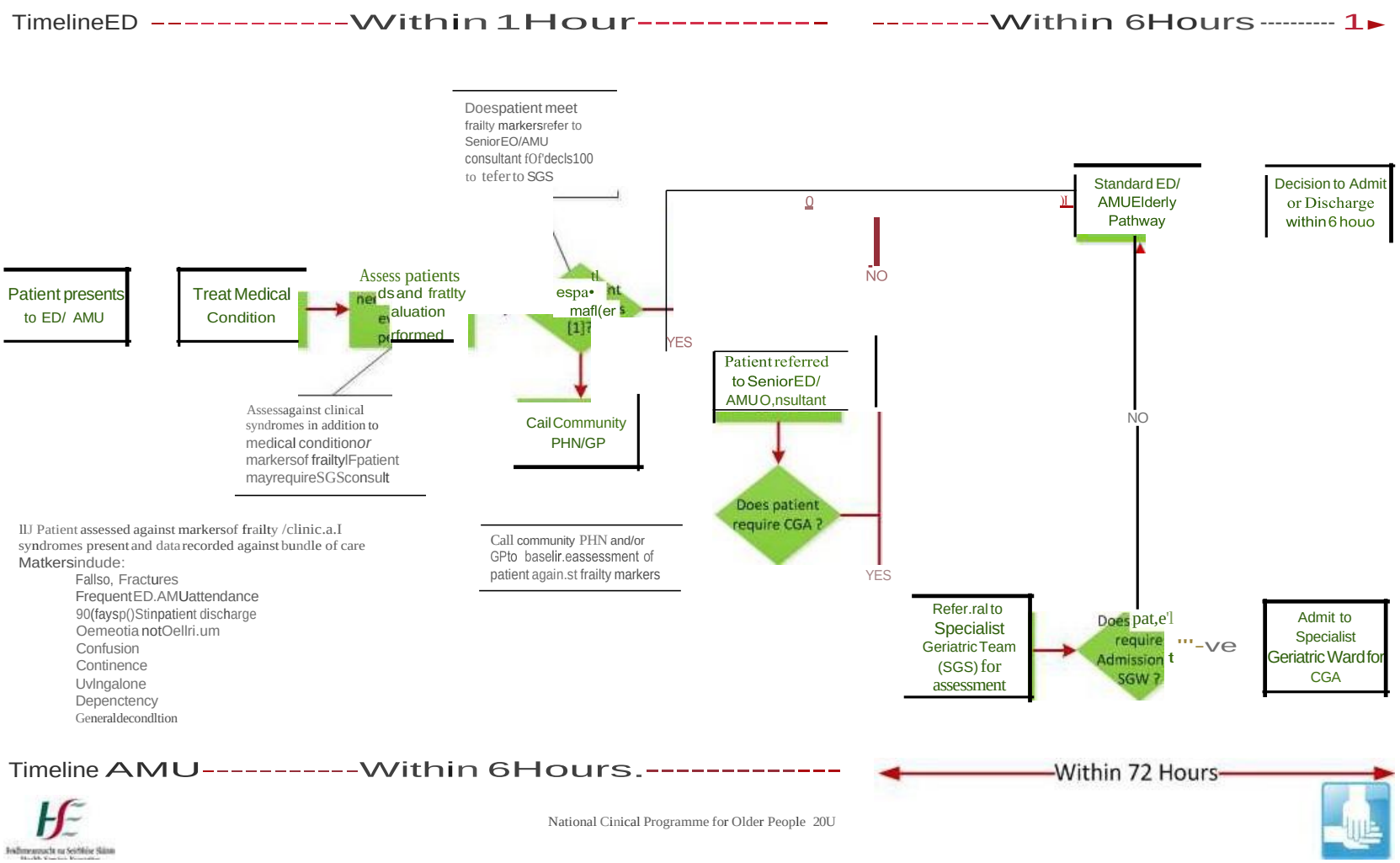
Formalised structures and care processes between the ED / AMU and SGS are required to:

1. Ensure that EDs and AMUs have a clearly defined strategy and written operational policy for the delivery of acute medical care for older people. Examples include:
    (i) Older patients should be prioritised in ED and seen by a senior doctor
    (ii) Older patients are discharged within 6 hours of presenting to ED
2. Carry out a comprehensive geriatric assessment on older patients and facilitate access to investigations; access to CGA for older people to be should be needs-based rather than arbitrarily age-based
3. Facilitate closer liaison between geriatricians, the ED and AMU staff
4. Facilitate access to services for older people, including rehabilitation, discharge planning, primary care services, application for home help / home care packages, long term residential care

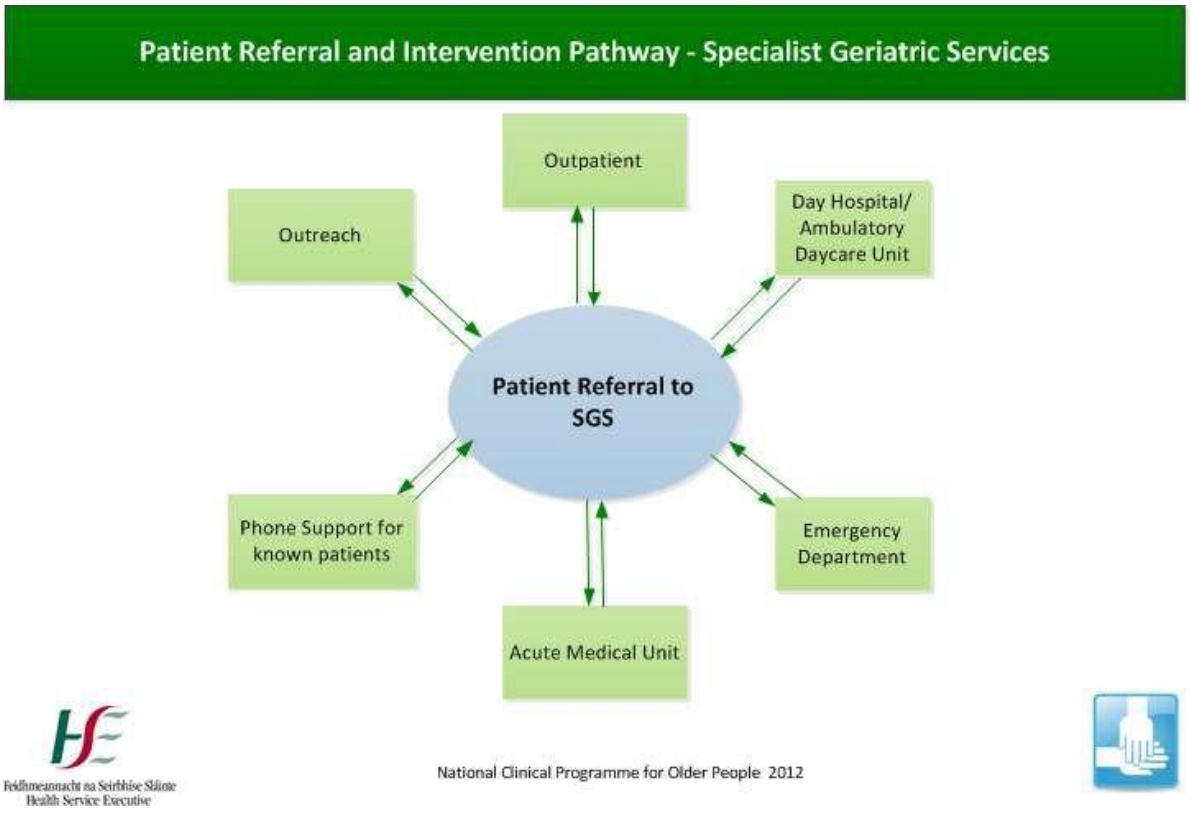
5. Liaise with case manager appointed as single referral point for primary care – as per Acute Medicine Programme
6. Provide training to ED / AMU staff on the care of older people.

Recommendation: The Specialist Geriatric Service will link with the ED and AMU when an older person at risk is identified requiring referral to SGS, including for CGA or admission to a specialist geriatric ward.

Older Patients Journey through ED/AMU



4.5.4 Referral to the SGT



Following needs assessment and clinical evaluation by a senior clinical decision maker with specialist gerontological knowledge, appropriate cases will be referred to the SGT.

Patients referred from general practice or from the community will be seen and assessed in the appropriate environment and timeframe. Based on assessment by a senior professional within the SGT they may be offered an appointment in the outpatient department, the day hospital be admitted to the SGW, receive phone support or an outreach consultation. The patient pathway can be delivered in a combined manner e.g. outreach visit followed by phone support.

Recommendation: Each SGS should have defined and agreed criteria with their ED, AMU and Community that determines whether a patient should be referred to the SGT.

Recommendation: Once referred, decisions about the appropriate SGS to meet the patient"s needs should be made by a senior professional to a specified timeframe.

4.5.5 Comprehensive Geriatric Assessment

A CGA is described as a multidimensional multidisciplinary diagnostic process focused on determining a frail older person"s medical psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long term follow up.

CGA is associated with better outcomes for the frail older person, i.e. reduction in disability, health improvement, less institutionalization, greater chance of living independently at home (Ellis et al 2011).

Older people are more likely to survive and return home if they receive CGA and related care whilst an in-patient. Fewer will suffer death or deterioration. These effects are consistently demonstrated from trials of SGWs. Inpatient CGA promotes a wellness and restorative approach to care.

CGA may occur in different settings e.g. specialist geriatric ward, other hospital ward, outpatient department, day hospital, AMU or on an outreach basis.

A CGA incorporates:

- multidisciplinary assessment
- geriatric medicine expertise
- identification of medical, physical, social and psychological problems
- the formation of a plan of care including appropriate rehabilitation
- ability to directly implement recommendations from CGA
- planned long term follow up

4.5.5.1 Components of a Comprehensive Geriatric Assessment

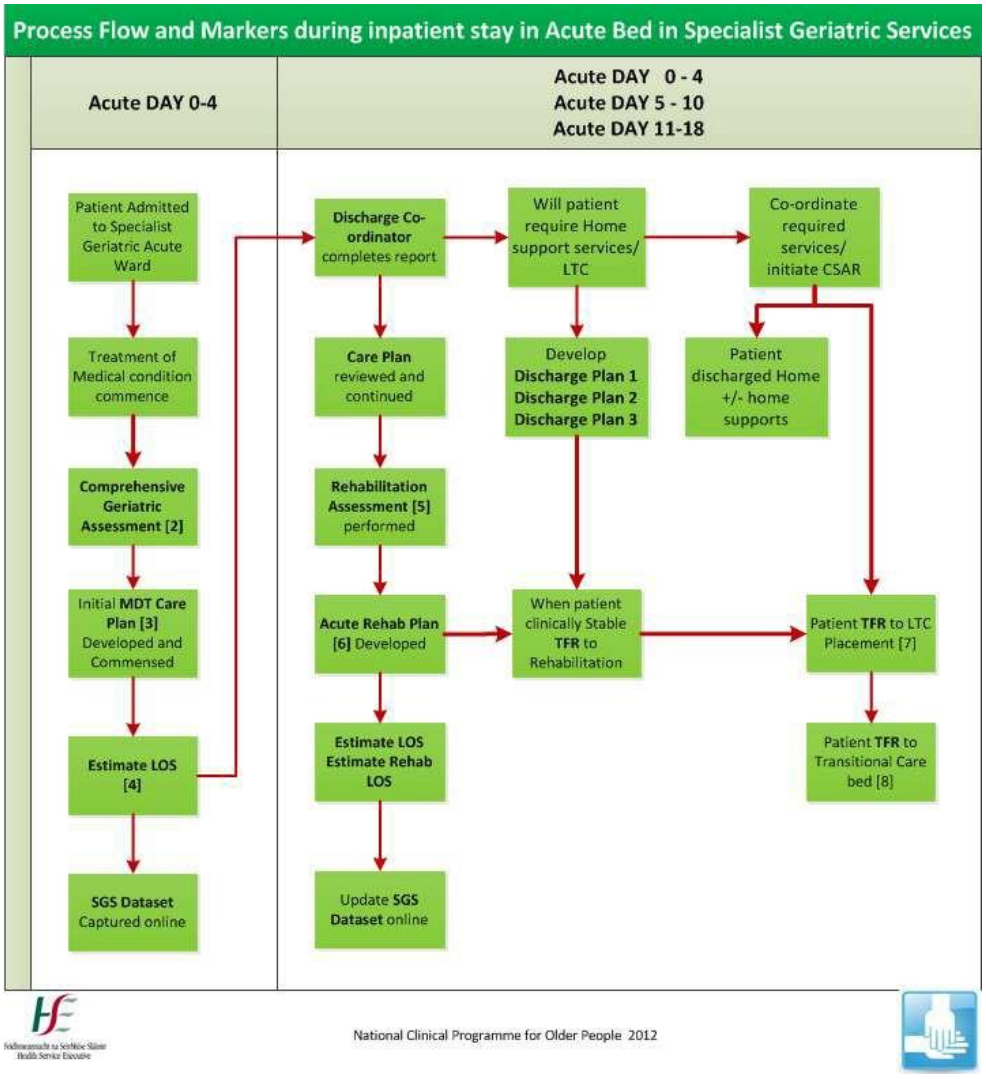
Component	Element
Medical assessment	Problem List Co-morbid conditions and disease severity Medication review Nutritional status
Functional assessment	Basic activities of daily living Instrumental activities of daily living Activity/exercise status Gait and balance
Psychological assessment	Mental status (cognitive) testing Mood/depression testing
Social assessment	Informal support needs and assets Care resource eligibility/financial assessments
Environmental assessment	Home safety Transportation and tele-health
Source:http://www.bgs.org.uk/publications/publicationsdownloads/compend_3-5_Comp_Assessment_hospital.doc	

Recommendation: All identified older frail patients to have a timely CGA performed and documented in their permanent health record that is accessible to both the primary and secondary care teams.

4.5.6 Specialist Geriatric Ward

There is clear evidence that a frail older person is more likely to be alive and in their own home up to a year after an emergency hospital admission if they receive coordinated specialist services. The Cochrane Review of Specialist Geriatric Care in Hospitals (Ellis et al, 2011) concluded that there is evidence of improved outcomes after emergency hospital admission, specifically lower mortality and increased probability of being at home (i.e. not back in hospital or transferred to long term care), when cared for in dedicated wards and a specialist multidisciplinary team in comparison with general wards. Key to this is that the staff on the wards are gerontologically trained.

Three other published meta-analyses (Baztan et al, 2009, Amed and Pearce, 2010, Bachmann et al, 2010) support these findings and report that specialist services (geriatric teams, wards, rehabilitation) are effective in terms of costs, improved function, reduced length of stay, readmission rates, cognition, reduced risk of admission to nursing homes, reduced mortality and patient / staff satisfaction. Research also indicates that interventions by individual professionals are rarely cost effective with this target group. However a dedicated multidisciplinary team has been shown to be cost-effective. Partial aspects of specialised care, such as early discharge planning or physiotherapy alone, were not judged effective, indicating that the benefit derives from the combined interventions of the team. Furthermore, multidisciplinary team responsibility for the patient ensures compliance with diagnostic and therapeutic recommendations and the implementation of the care plans.



Please see Appendix 4 – Care of the Older person Pathways and Process Flows

Recommendation: Each hospital receiving acutely ill older adults must have a dedicated Specialist Geriatric Ward with appropriate staffing levels and a designated MDT

4.5.7 Inpatient rehabilitation

Rehabilitation is a core element in the practice of medicine for older people involving multi-disciplinary physiotherapists, occupational therapists, speech and language therapists, clinical nutritionists, psychologists and others. Chapter 5 provides further information on a rehabilitation programme for older people.

Decreased functional ability can lead to an increase in length of stay in hospital and / or create a necessity for admission to a nursing home. It can create a higher burden of care for families and may create additional burdens for PCT supports and home care. It can lead to further deterioration at home, as the person continues to decline and do less for him/ herself, and may be a contributing factor to subsequent falls.

There is evidence to support the rehabilitation of older patients to ensure early discharge back to the community and avoidance of institutionalisation. Rehabilitation must start early in the inpatient stay in order to minimise loss of function during admission, to promote and regain functional ability following the acute illness and avoid the further functional deterioration that often occurs with hospitalisation.

Rehabilitation should be an integral component of the care of all older people admitted to the acute care setting. To enable this to happen, rehabilitation beds must be available on and off acute hospital sites with good communication and IT infrastructure between units and teams to ensure that the patient rehabilitation journey is seamless. These rehabilitation beds must be appropriately staffed by a multidisciplinary team. Some patients may not require an acute hospital admission but may require an admission for in-patient rehabilitation. Primary care teams or SGTs will identify these patients and arrange admission. Access via this route is important. If timely access to an inpatient rehabilitation bed can be provided for those in the community, this may avoid further functional deterioration which increases the risk of acute hospitalisation and institutionalisation.

Please see Chapter 5 Rehabilitation of the Older Person.

Recommendation: Each hospital has access to onsite and off-site rehabilitation beds and delivers a structured rehabilitation programme for older people.

4.5.8 Discharge Planning

Effective multi-agency and multi-disciplinary working is essential to manage the patient"s journey from preadmission through hospital discharge to the community. The principlies are the same as in the Acute Medicine Programme (Section 8): patient-centred discharge planning to commence soon after admission, integrated within the hospital and between healthcare settings. Current policy to expand health and social services in the community

will facilitate timely discharge from the acute hospital. Discharge destinations for older patients in this Pathway are classified as follows;

Discharge Plan 1: **Home** with or without home supports, with follow-up by primary care or follow-up in OPD or day hospital

Discharge Plan 2: **Not home** (e.g. offsite rehabilitation, other acute site) with ambulatory follow up in OPD, day hospital or primary care, community

Discharge Plan 3: **Extended Care** To long term residential care, including via transitional care

Recommendation: A systematic approach to discharge planning will be facilitated by admission of the frail older person into an SGW with an SGT. Each hospital to have an SGT, with clear responsibility and processes for CGA, integrated discharge planning, and communication with the patient and professionals in other care settings.

4.5.9 SGS outpatient and rapid access clinics

Pathways and protocols of care should be consistent across the SGW, OPD and the DH. This will be facilitated where staff work across these settings, Where staff work do not work across these settings, e.g. staff working in the DH, education, training and regular meetings will be required to ensure consistency in care processes.

Services to be provided for older people in the specialist OPD and the DH will be specified in each hospital, to enable professionals to refer patients to the most appropriate setting. For example, it is proposed that patients requiring CGA or input from the SGT on an outpatient basis be referred directly to the DH (section 4.5.10).

The OPD is an appropriate setting for referral:

- From general practice or other community setting for specialist consultation about non-urgent symptoms and signs
- For review after attendance at the ED, AMU or DH or on discharge from inpatient care.

Monitoring access and attendance at the OPD will indicate changes to improve efficiency e.g.:

- ensuring sufficient capacity for rapid access by patients referred from the ED, AMU or community
- ensuring sufficient places for new attendances
- discharging patients for continuing care in the community
- implementing „shared care" with general practice in collaboration with other clinical programmes

Recommendation: Recommendation: Each SGS will provide and outpatient services which encompasses subspecialty clinics with rapid access slots for urgent referrals.

4.5.10 Day Hospital on the acute site

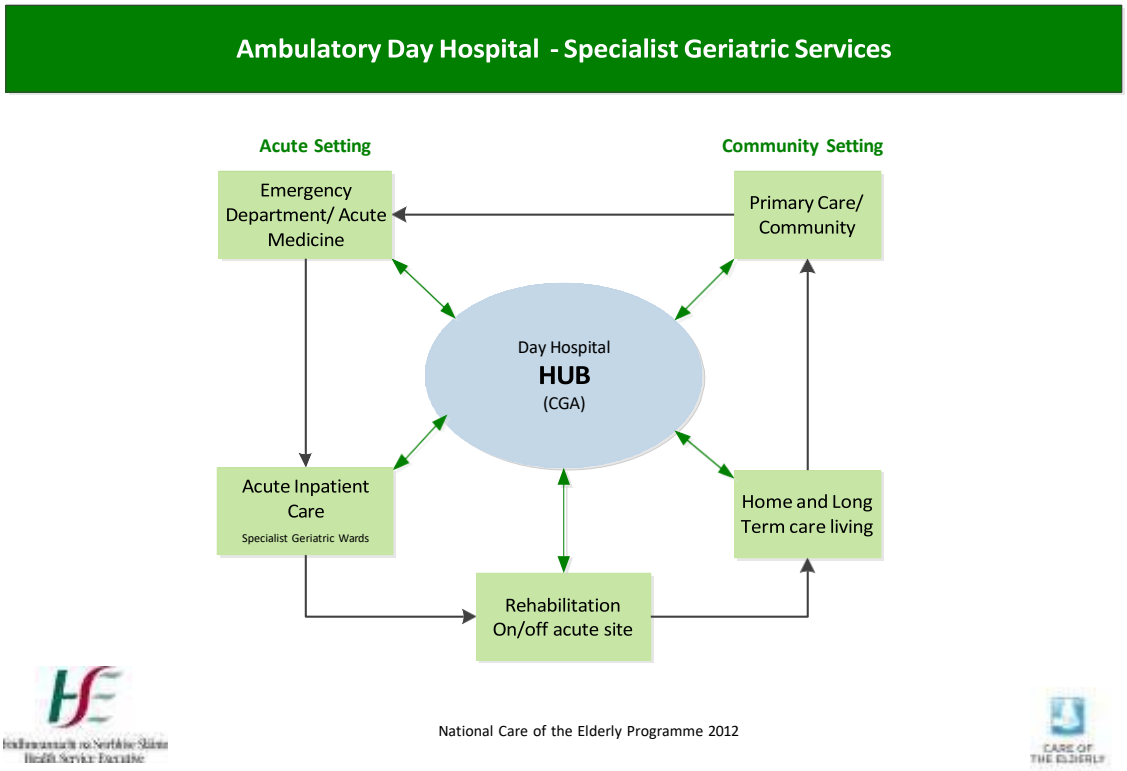
The DH will be the setting for acute ambulatory services. It will also function as the co-ordination, information and training hub for services for older patients, supporting

integration between hospital and community based services. In addition it will act as a resource for others involved with the care of older people.

A geriatrician will be the lead clinician for the DH, working with assigned members of the SGT. Patients will access DH services via the community or by referral from the ED, AMAU / AMAU / MAU or OPD. The DH will operate on weekdays between 9am and 5pm.

Frail patients who have been discharged from the ED or AMU / AMAU / MAU may be referred to the SGT for early assessment and follow up in the DH. Rapid access appointments will be provided for patients in the community to avoid a visit to the ED. GPs will be able to access appointments at short notice. Patients attending the DH will have a multidisciplinary CGA. There will be the same access to diagnostics as for patients attending the MAU.

After assessment and the development of a care plan, the setting in which the care is delivered with depend on local configuration of services. The patient may be referred elsewhere for rehabilitation and treatment, or could receive treatment and rehabilitation in the DH.



Recommendation: Each hospital receiving acutely ill older adults must have an onsite day hospital capable of meeting the needs of the catchment area population.

4.5.11 Outreach to long term residential care facilities

Currently some geriatric specialist teams provide such outreach services from some acute hospitals and have evaluated the benefits in improving the quality of patient care.

A Specialist Geriatric Outreach services is delivered from the acute hospital setting to residents in nursing homes and extended care facilities as these are by definition the most frail older persons with most complex diseases.

Outreach services may also develop to provide / support services in primary care centres and community hospitals.

Functions of the SGS Outreach:

1. Provide a consultation service for patients in long term residential care facilities referred by the GP or Medical Officer.
2. Develop, in liaison with primary care and health and social care professionals, training and education of primary care providers in the delivery of quality care to nursing home residents with particular emphasis on appropriate medication review and management of chronic long-term illness. Targeted programmes will be delivered by nurse specialists and health and social care professionals to support quality improvement in extended care settings e.g. speech and language education on safe feeding practice in dementia care.
3. Support the primary care MDT as the patient moves to the acute setting on discharge e.g. post-stroke patients discharged from rehabilitation to extended care.
4. Develop and implement communication systems between hospital-based services and primary care providers, including GPs and Community Interventions Teams.
5. Facilitate cross-specialty activity with psychiatry for older persons, primary and palliative care services, e.g. advance care planning and end of life care pathways in local extended care settings.
6. Support compliance with the Health Information and Quality Authority (HIQA) standards.

Benefits of SGS Outreach:

- Improved quality of health care to frail older people with complex care needs
- Appropriate use of acute medical services for this high-need group
- Facilitates appropriate early discharge planning and reduces length of stay in acute hospital
- Reduces inappropriate medication by providing a consultation service in long term care
- Older patients having access to specialist outreach care may reduce the re-admission rate
- Avoid inappropriate hospital admission by developing advance care planning and end of life care plans in association with the Palliative Care Programme
- Improved access to community-based multidisciplinary services including physiotherapy, speech and language therapy, occupational therapy and dietetics
- Improved communication with general practitioners, nursing homes, families and other services appropriate to the needs of this patient group
- Closer liaison between geriatricians, the ED, AMU and primary care will benefit patients and improve staff training.

Recommendation: Each SGS will provide an Outreach service, prioritising patients in long term care referred by the GP or Medical Officer. The Outreach

service will also liaise with psychiatry for older persons and support training and education of community based staff.

4.5.12 Working with Community Based Services

The primary aim of the reconfiguration of gerontology services within the acute hospital system as proposed by the clinical care programme is to ensure that key personnel in acute hospitals are up-skilled to manage and aid the recuperation of those with complex care needs. Subsequent discharge home of this cohort of older people demands an integrated discharge plan that requires effective working, knowledge and communication with primary care teams (PCTs).

Enhanced SGS in the acute setting will provide the General Practitioner or the PCT, via the GP, with a single point access link to the Specialist Geriatric Team (SGT):

- Referrals will be made electronically, by phone or by fax
- Direct GP/PCT access to a doctor in the SGT for patient discussion should be available
- Fax/electronic link detailing outcome returned to source of referral on the day patient is seen
- Implementation of the Single Assessment Tool may facilitate this process.

It is essential that liaison around the discharge process is enhanced not only by the SGT, but also by the facilitated response of primary care networks based in the acute hospital catchment / integrated service area. As PCTs have a local geographical population focus to the delivery of their health care services, it is important that primary care networks reconfigure resources to develop a dedicated community based network interdisciplinary team for frail older people. This community-based MDT for Older Persons can serve the wider primary network by acting as the focal point for both discharge planning and the early identification of frail older people

The liaison link for referral and discharge should be facilitated by a clinical working relationship between a designated member of acute hospital SGT and the MDT for Older Persons. The MDT team can undertake an initial assessment of care needs in conjunction with the CNS Gerontology. Where indicated, the person can be referred to hospital for the CGA. Where this assessment takes place (DH or AMU) will depend on the acuity of the person‟s needs and the illness.

Recommendation: The establishment of SGTs in acute hospitals will facilitate communication with GPs and PCTs. A single access point will be established to support referral. Outcome of hospital assessment and care will be communicated in a timely manner to the referral source.

4.6 Pathway Enablers

Achieving high standards of care for frail older people will require:

1. Understanding the needs of older people and a strategic plan to deliver services which address them
2. Involvement of older people, including carers, in service planning

3. Partnership working between staff based in acute hospitals, general practitioners, primary care and other community settings. Part 2 of the Model of Care will include partnership with other stakeholders, including the voluntary sector and local authorities,
4. Recognition of the role and structure of the interdisciplinary team with realignment of hospital based services to develop integrated specialist services for stroke, falls/fractures and osteoporosis, intermediate care support and mental health services for depression and dementia
5. Older people must be represented, consulted and involved in local planning and decision making
6. Local champions for older people are identified at each level including non-executive director lead and clinical leads. The clinical leads should come from the specialist departments
7. All clinical policies are regularly reviewed to ensure no age bias
8. Resuscitation policies are reviewed to ensure concordance with national guidelines
9. Needs of ethnic and religious minorities are represented and incorporated in departmental protocols and local planning
10. Staff of all types in care of older people units need to be trained in geriatric medicine
11. Staff should be empowered to challenge behaviours and help change attitudes in their own and other departments
12. Older people should at all times be treated as individuals and offered choice in treatment, discussion and planning of future care
13. Services need to be modelled so as to be easy to access regardless of the end provider
14. Older Persons Case management enabling the monitoring of movement of the frail older person through their acute journey and actively case managing their discharge ensuring referral for services and response times are being met.
15. The single assessment tool should be used in all departments

Recommendation: The interRAI single assessment tool should be available to primary and secondary care services to facilitate care of all identified frail older adults

4.7 Critical Factors Effecting Implementation

- Accurate and accessible data collection e.g. the Single Assessment Tool
- Demographic data and trends, especially increasing numbers of frail older people
- Social factors: housing, living alone, carers
- Departmental management structures to implement coordinated multidisciplinary care
- Adequate resources – structural and staffing - for all components of the service
- High quality, measurable standards for all components of the service
- Access to services - clear pathways of referral as well as the capacity to respond quickly and appropriately to care needs; physical access to service settings

- Continuing education, training and development for all grades of staff
- National and local socio-economic factors

4.8 Specialist Geriatric Service Process Priorities

4.8.1.1 Inpatient Process priorities

- **All** frail older patients are identified and admitted to specialist geriatric ward (where appropriate)
- All of these patients get Comprehensive Geriatric Assessment by a multidisciplinary team (where appropriate)

4.8.1.2 Staffing priorities

- Dedicated Specialist Geriatric Team (SGT) in each hospital.

4.8.1.3 Communication priorities

- Enhanced communication is essential at several points in the patients pathway; most systems are currently paper based which is slow and risky.
- The NCPOP data set to be recorded for each patient to determine processes are in place, to monitor outcomes and identify barriers to discharge after the patient is ready to be discharged

4.8.1.4 ICT supports

There is a requirement for data to be captured throughout the patient"s journey. The *NCPOP* will develop a data set to be captured for the acute episode. It is likely that this will be through HIPE Portal, managed by the ESRI. Each SGT will record data in the HIPE Portal in relation to patient assessment, communication and discharge planning. This will support SGTs to monitor service developments and to audit local against national performance and Programme targets.

The Programme is cognisant of the Single Assessment Tool (SAT) which is currently being rolled out in community services. It is important that data recorded in the acute setting is compatible with the SAT. Future developments will facilitate availability of the patient"s information across the community and hospital interface.

Priorities for development:

- Community / hospital interface: Referral in / discharge summary out. Ideally all professionals in the hospital and in the community who are involved in a given patient"s care should be able to access the patient record in real time

- Inpatient Management: Requesting investigations and accessing reports – this identifies those who request and report, it facilitates clinical audit. This applies to radiology, lab, therapy, pharmacy and other assessments/ investigations.

The Single Assessment Tool [pilot phase to Q1 2012] will assist this entire process.

4.9 Standard Operating Procedures

The *NCPOP* will develop a number of standard operating procedures (SOPs) and pathways to support the Model of Care. The SOPs are to be adapted locally to fit with the service model that will be adopted at local sites.

A list of SOPs is below and will soon be available as separate appendices and on www.HSE.ie

SOP	SOP Name
1	Management of frail older person in the community (Part 2 Model of Care)
2	Management of frail older person in primary care (Part 2 Model of Care)
3	Management of request for assisted discharge packages for frail older patients (Part 2 Model of Care)
4	Management of CSAR application process for frail older patient (Part 2 Model of Care)
5	Management of day hospital referrals ▪ New patients ▪ First visit to day hospital ▪ Return visit to day hospital ▪ Patients on day hospital waiting list ▪ Management of discharge of patients from day hospital
6	Management of frail older patient through ED/AMU (Triage and Streaming)
7	Management of frail older patient in Acute Geriatric Care Ward (including acute inpatient rehabilitation)
8	Management of frail older patient in onsite / offsite/ extended rehabilitation
9	Management of the discharge of frail older person to transitional care bed process
10	Management of the frail older patient in transitional care bed (temporary accommodation
11	Management of the discharge of frail older person to long term residential care facility from Hospital, Rehab or Transitional bed.
12	Management of frail older patient in long term residential care
13	Delivery of outreach services to long term residential care, community rehab and transitional care facilities

5 Rehabilitation of the Older Person

„To improve opportunities for all older people to live at home and remain as independent and healthy as possible and able to participate in community life"

5.1 Comprehensive Geriatric Rehabilitation

The majority of older persons live successfully, independently in the community. From time to time acute medical or surgical events occur and result in functional loss for an individual. Rehabilitation may reverse – partially or completely – this functional loss. Older adults should have access to rehabilitation in the most appropriate location for them – i.e. either community or inpatient. A key component of successful rehabilitation is communication between the different service providers and rehabilitation teams – i.e. integrated care, in order to best serve the individual needing rehabilitation.

Key features of successful rehabilitation programmes focus on:

- Generic syndromes of ageing that require rehabilitation intervention
- Early identification processes
- Early intervention for reversible conditions
- Improved management and timely transitioning of older people in the acute setting
- Recognition of the interplay of co-morbidities and conditions of ageing on management of older people in the acute setting
- Sensitisation of medical and health and social care staff to the early rehabilitation care needs of the older population.

Summary of Evidence Based Recommendations for Geriatric Rehabilitation Unit

Patients should have preadmission screening for rehabilitation potential prior to admission to a rehabilitation unit (level 3 evidence).

- Assess: functional impairment, medical complexity, psychological functioning, and social support.
- Exclude: patients who are too medically unstable, more appropriate for palliative care, or can be treated at home as outpatients.
- The screening process should be used to establish well-defined, patient-focused goals for rehabilitation (level 3 evidence).

Comprehensive Geriatric Assessment (CGA)

- CGA is important for frail older persons with rehabilitation needs (level 3 evidence).
- Close medical supervision and concomitant treatment for intercurrent and comorbidities is important (level 3 evidence).

Assessment Tools

- Assessment tools should be used to aid in diagnosis and to measure outcome of rehabilitation (level 3 evidence).

Team Approach to Care

- Geriatric rehabilitation should have an multidisciplinary team approach (level 1 evidence).
- Medical care and rehabilitation should be managed by a physician and team

trained in care of the older person (level 1 evidence).
- The rehabilitation team physician and pharmacist should complete a medication review (level 3 evidence).
- Patients with complex medication regimes who are returning to community living may benefit from a self-medication program (level 1 evidence).

Hip Fracture

- Frail older persons with hip fracture should receive geriatric rehabilitation (level 1 evidence).

Nutrition

- Frail older rehabilitation patients should receive nutritional screening (level 3 evidence).
- Nutritional intervention should be provided to under nourished frail older rehabilitation patients (level 1 evidence)
- Individualised treatment plan and dietary interventions should be provided to frail older patients with dysphagia (level 2 evidence)
- Gastrostomy tube feeding is superior to nasogastric tube feeding for older stroke patients with long term severe dysphagia (level 1 evidence)
- The nutritionally at risk older patient with hip fracture may benefit from nutritional intervention(level 1 evidence)

Depression

- Frail older rehabilitation patients should be screened for depression and treatment plans initiated with appropriate (level 3 evidence)

Cognitive impairment

- Frail older patients should be screened for cognitive impairment (level 2 evidence)
- Frail older rehabilitation candidates with mild to moderate dementia should not be excluded from rehabilitation (level 1 evidence)

Reference: Lewis D. 2008, Organization Design for Geriatrics: An Evidence Based Approach

Levels of Evidence	
Level 1:	Evidence from at least one randomized control trial
Level 2:	Evidence from well-designed controlled trials without randomization or from well-designed cohort or case control analytic studies
Level 3:	Evidence supported by consensus statements from experts, opinions from respected authorities, descriptive studies, or reports of expert committees.

5.2 A Rehabilitation Programme for Older Persons

5.2.1 Introduction

Frail older persons commonly manifest illness by functional decline. Admission to acute care hospital may accentuate this functional loss. There exist missed opportunities to recognise and treat functional decline as well as the acute medical or surgical problem i.e. older adults may benefit from geriatric rehabilitation both in the community and in hospital. Geriatric rehabilitation has been defined as “evaluation, diagnostic, and therapeutic interventions whose purpose is to restore functional ability or enhance residual functional capability in older people with disabling impairments”. The key elements for successful

geriatric rehabilitation are trained multidisciplinary team, comprehensive geriatric assessment, appropriate prompt recognition and treatment of underlying medical conditions, functional impairments, cognitive impairment as well as psychosocial problems. The location of the rehabilitation may be a dedicated unit in the acute hospital or in an offsite hospital as well as in the community.

Older people should have equal opportunity to access these services independent of geography. The majority of older patients [approx 70%] admitted to a rehabilitation unit will be discharged home. A significant minority may require extended care. Rehabilitation units in hospital and programmes in the community should have clear processes for admission to the programme, provision of rehabilitation and discharge from rehabilitation.

5.2.2 Background

There are published data to support general rehabilitation of older patients to ensure early discharge back to the community and avoidance of institutionalisation. In particular there is strong evidence that ortho/geriatric rehabilitation i.e.; rehabilitation of old patients **post hip fracture**, reduces morbidity and mortality and length of stay in hospital. There is compelling evidence that rehabilitation of older patients with **stroke** reduces morbidity and mortality, reduces the need for long term residential care and allows discharge back to the community. There is also evidence showing value of rehabilitation in older people in long term residential care.

5.2.3 Key Actions of Effective Multidisciplinary Geriatric Rehabilitation Teams

- Key team functions are assessment, interventions / treatment, and discharge planning
- The team apply screening criteria to select older persons with rehabilitation potential
- Multidisciplinary team approach and model of care coordination
- Regular team rounds
    - Team rounds once per week and MDT meeting weekly
    - Review interval determined by consistent intervals
- MDT sets goals with patient in the first week
- Core MDT membership includes amongst others;

- A key worker is appointed for the patient and family liaison – this is usually the team member with the most input to the patient.
- The primary goal is to maximize the patient"s functional independence via the World Health Organisation International Classification of Functioning, Disability and Health (ICF) in the domains of function, participation and activity
- Joint decision making and responsibility with open communication, cooperation, and respect for each team members" expertise
- Negotiated of roles and tasks to accomplish mutually defined goals
- A team leader should be agreed
- Medication review is important and teaching patients to safely self-medicate is an important part of discharge planning
- Discharge planning, possibly including a home visit(s) is an important function of the team – there are HSE guidelines around discharge planning – see sample SOP
- Collaborative relationships between team members, patients, and family members, family meetings, particularly around discharge planning enable safe discharges

see also SOP# 8

5.2.4 Access to rehabilitation

Most older individuals with loss of function demonstrate improvement with MDT rehabilitation. A small minority will not benefit. A screening process should occur before admission to a rehabilitation unit / programme. This needs to involve the MDT. In patients who do not have clear rehabilitation potential, they may be admitted to the programme for a short assessment phase. In any event before admission to the programme a clear discussion with the patient and their advocate should explain likely outcomes of rehabilitation, likely duration of rehabilitation, clear descriptions of processes and therapy inputs so that the patient"s and advocate / family have realistic expectations of the rehabilitation programme and can give informed consent to admission to the unit / programme. A clear standard operational procedure should exist for all rehabilitation programmes.

Example: two or more of the following risk factors may indicate a need for early involvement of MDT for rehabilitation and discharge planning or unmet medical needs

- Difficulty with mobility
- A history of recurrent or multiple falls
- Cognitive Impairment
- One or more unplanned admissions in the previous three months
- A stroke in the past three months
- Difficulty in performing one or more basic ADL in the three days prior to admission
- Poor nutritional status
- Continence issues

5.2.5 Education and training

In order to deliver quality care all staff members of the MDT must be trained and supported to provide services to the older person. They may need subspecialty training in specific instances e.g. stroke, orthogeriatrics, dementia care. Essential competencies will be in the job specifications. They must have experience in the team approach to management of the patient. CME and CPD must be maintained and supported to maintain quality in the rehabilitation programme.

5.2.6 Communication

A key component of successful rehabilitation is communication between the different service providers – i.e. integrated care. Systems and tools must be available to implement this. Agreed care pathways, IT systems [e.g. SAT], agreed roles and responsibilities of the teams within community and hospital and clear agreed timely means of communication are central to quality patient care.

5.2.7 Facilities in a Rehabilitation Unit

Rehabilitation is multidisciplinary in nature and therefore there are facilities needed to support this; including multi-users; beds if appropriate; areas for each member of the MDT to practice i.e. gym, kitchen, offices etc. For inpatients the space requirement is somewhat different from acute „beds" as many patients have wheelchairs and walking aids and appliances, and in order to train patients in their use sufficient space must be allowed in the bed surrounds, as well as complying with building regulations [national Disability Authority] and HIQA. The environment should allow for the fact that patients may spend some weeks in this area have active rehabilitation prior to going back into the community. Protocols for service provision and patient flow will maximize its effectiveness.

- This unit will have close links with rheumatology, geriatric medicine, orthopaedic surgery, cardiology, gastroenterology among others.
- In inpatient rehabilitation the beds required are 3/1000 and can be calculated from population. One caveat is to ensure that they are provided close to the population geographically i.e. the population profile and geographic location of the population - must match the provision.
- Serviced by normal ward structure – the areas should be accessible by wheelchair and allow assisted living i.e. for showering etc.
- Additional environmental areas [a] for comfort if hospital stay is prolonged [b] to develop independence i.e. day room / outdoor / garden area / relatives area.
- Staff offices and treatment areas for above staff.
- Gyms – two large gyms to include group as well as segregated areas where patients who require privacy / segregation can be treated i.e. MRSA or amputee patients
- Occupational Therapy areas for splinting; kitchen areas for assessment; driving assessment area; quiet area for cognitive assessment and treatment.
- An additional day assessment and patient area for OPD including armchairs / day.
- Conference room for MDT meetings / group patient education sessions.

- Additional offices for other treatments i.e. multipurpose: chiropody, wound management, counseling, chaplaincy.

5.2.8 Governance of Patients in Rehabilitation

All Rehabilitation services must have the necessary arrangements in place to ensure that there is a named consultant clinically responsible and accountable for a patient‟s care at all points in the patient journey and throughout their hospital stay.

Patients remain under the care of the referring Geriatrician for onsite inpatient rehabilitation.

Some patients may remain under the care of the referring Geriatrician while some patients will be under the care of the medical officer in the rehabilitation unit.

5.2.9 Workforce Planning for Health and Social Care Professionals

In line with international evidence and research, the following staffing levels are recommended:

Per 20 bed care of the older person inpatient rehabilitation unit

Physiotherapy	4 WTE	2 Senior, 2 Staff Grade
Occupational therapy	4 WTE	2 Senior, 2 Staff Grade
Speech and language therapy	2 WTE	1 Senior, 1 Staff Grade
Dietetics	1 WTE	Senior Grade
Podiatry	1 WTE	Senior Grade

All disciplines should be included for an effective multidisciplinary team and have access to medical social work, assistant therapy grade staff, clerical support, ICT and other services where indicated

5.3 Rehabilitation in the Community (non inpatient)

The principles of rehabilitation are constant no matter where it is delivered. The core MDT structure and function is also the same. The operational procedures may have to be adjusted. Flexibility in the service must allow the patient‟s need to dictate the most appropriate location for rehabilitation. The preferred option is to maintain the patient in their own home if possible. If rehabilitation is to be delivered as an outpatient service, it must be valued and supported.

There are many sites at which non inpatient rehabilitation may be delivered:

- The patient‟s home, including long term residential care
- Health centers
- Day hospitals
- Community units

In many areas existing community rehabilitation teams and district care teams have been stepped down or been subsumed into primary care teams. The Model of Care Part 2 will address non inpatient rehabilitation for older people.

5.4 Comprehensive Geriatric Rehabilitation Recommendations

- It is a fundamental right of the older person to receive an adequate period of rehabilitation before a decision with regard to long-term care is made.
- A clear standard operational procedure should exist for all rehabilitation programmes.
- No older inpatient should be "waiting for rehabilitation"
- Each hospital has access to onsite and off-site rehabilitation beds and delivers a structured programme.
- Educate and enable health care personnel in all sectors to recognise frail older person using simple tools, and educate them as to rehabilitation services and referral pathways
- Rehabilitation programmes for the older person should be responsive to this need and have capacity to provide appropriate service in the appropriate location.
- Integrate inpatient and non-inpatient rehabilitation via a liaison role.
- Support a dedicated model of care that focuses on Day Therapy Centre (currently termed outpatient Day Hospital) to deliver rehabilitation programmes.
- Establish CREST teams for community to improve organization, delivery and review of community rehabilitation and home care services to those frail older people living in their own homes. These teams are linked to a Dept of Geriatric Medicine in an Acute hospital [in rural areas this system may need to be tailored to meet geographic constraints]
- Ensure that Rehabilitation in the Home programmes are established from hospitals with inpatient rehabilitation units to facilitate timely and appropriate discharge.
- Expand Rehabilitation in the Home programmes to include domestic and personal support so that the older person can be better supported at home during the recovery process.
- Older people in long term residential care should have access to rehabilitation when needed.
- Integrated systems should facilitate smooth transition and access for the patient to the most appropriate service in the most appropriate location.
- Develop and implement a good communications system for delivery of rehabilitation to older people in the Irish Health care system.
- Support services including voluntary sector should be facilitated
- Rehabilitation involves a client focused journey in which the client must take an active part
- Rehabilitation be provided on the acute hospital site must be adequately resourced in terms of staff and facilities
- Inpatient rehabilitation may be provided offsite if adequately resourced in terms of staff and facilities
- Non inpatient rehabilitation must be adequately resourced in terms of staff and facilities

- CME and CPD must be maintained and supported to maintain quality in the rehabilitation programme
- Improve organisation, delivery and review of community delivered rehabilitation and home based rehabilitation services to those frail older people living in their own homes. This will be addressed in Part 2 of the model of care for SGS

6 The Specialist Geriatric Team

Each hospital should have a specialist geriatric service. The members of the SGT must be ring-fenced and dedicated to SGS with clinical reporting relationship to the Geriatrician. The team should have an appropriate mix of grade and should develop or maintain core competencies for this area. This section covers the members of the team, their key roles and responsibilities and interfaces with other services.

6.1 Members of the SGT

The Specialist Geriatric Team"s (SGT) core members are:

- Consultant Geriatrician
- Clinical nurse specialist
- Physiotherapist
- Occupational therapist
- Speech and language therapist
- Medical social worker
- Clinical nutrition services
- Business management/administration support

Plus access to:

- Orthoptist, pharmacist, psychologist/ psychiatry for old age, podiatrist, audiologist and others

6.2 Roles and responsibilities within Specialist Geriatric Team (SGT)

6.2.1 Leadership

The Geriatrician will provide a lead role within a SGT team which is multidisciplinary.

The team requesting the assessment will outline the identified deficits and requested interventions for the patient being referred. With time it would be expected that the accuracy and appropriateness of the referral process would improve. The core function of the team is to provide education and guidance for the team looking after the patient and conduct where necessary a comprehensive geriatric assessment.

The attached Appendix 2 – Roles of the Specialist Geriatric Team outlines in greater detail the roles and responsibilities of each team member as listed above. Each professional group have outlined their own roles in further detail. This is not meant to be an exhaustive account of each of the roles, but as start for developing such a team and service that will deliver care to the frail older person. Professional competency frameworks will dictate exact professional responsibilities and reporting structures for that discipline.

6.2.2 Geriatrician

The Geriatrician will provide lead role being particularly involved in developing an investigation, treatment, rehabilitation and discharge plan for the patients which will be

discussed with the other members of the team. There will be regular multidisciplinary, educational and audit meetings for the purpose of maintaining standards and reviewing implementation of and adherence with developed guidelines.

6.2.3 Coordinator

Identify team coordinator. Note, this does not need to be a separate WTE and is not the remit of any one discipline it could be a rotating post ensuring all members of team take turns.

6.2.4 The Nursing Team

The role of nursing is critical in delivery of the model of care. The enhancement of nursing roles in older persons care supports the provision of a timely quality service to the frail older person, promoting healthy aging and optimum levels of independence.

Clinical Nurse Specialists (CNS)/ Advanced Nurse Practitioners (ANP)

CNSs work with the multi-disciplinary team to provide specialised assessment, planning, delivery and evaluation of care using protocol driven guidelines.

Care delivery and caseload management is delivered in line with core concepts (clinical focus, patient/client advocacy, education and training, audit and research, consultancy) (NCNM 2008a).

ANP"s caseload involves holistic assessment, diagnosis, autonomous decision making regarding treatment, provision of interventions and discharge from a full episode of care. Care delivery and caseload management is provided by ANPs in line with core concepts (autonomy in clinical practice, expert practice, professional and clinical leadership, research) (NCNM 2008b, c).

Staff Nurses

Staff nurses are integral members of the multi-disciplinary team providing significant clinical care for individuals and families in a wide range of settings including acute, community, residential and extended care settings and homes. They provide comprehensive patient assessments to develop, implement and evaluate an integrated plan of healthcare, and provide evidence-based nursing interventions. The staff nurse engages in monitoring and evaluating the patient"s response to interventions and treatment.

Healthcare assistants

Patients/clients may require assistance in some or all activities of daily living. It is the duty of the nurse to assess, plan, implement and evaluate the care required by the patient. The primary role of the health care assistant is to assist the nurse in the implementation of the care, as determined by the registered nurse.

6.2.5 The Health and Social Care Professionals

Health and Social Care Professionals use a multi disciplinary approach to promote, maintain and restore physical, psychological and social wellbeing of the frail older person, taking account of variations in health status. H&SCPs also provide education, training and

support to the older person, family/carer. There is clear evidence that multidisciplinary intervention consistently benefits the frail older adult. Multi disciplinary interventions are effective in the acute, sub acute, community and long term residential care settings. It is important that the appropriate skill mix of H&SCP is maintained on the specialist ward. This can be a mix of senior, staff or assistant grades. The recommended staffing levels and skill mix provided by the Therapy Professions Committee is outlined in section 6.6. The role of the therapy profession is summarised below. A more detailed definition can be found in Appendix 2 or the specific job descriptions/competency frameworks for these roles.

Physiotherapist

Physiotherapy-led interventions are effective in the acute, subacute, community and residential care settings (Forster, 2010; Daniels, 2008). Evidence has shown those interventions can:

- Reduce falls risk and incidence of fracture
- Maintain and improve functional ability including gait
- Exercise improves cardiorespiratory function, muscle function, flexibility, physical activity participation, functional ability and continence of frail older adults. (Theou et al, 2011; Dumoulin, 2010)

Occupational Therapist

Occupational therapists (OT) as key members of the multi-disciplinary team, provide specialised assessment, planning and treatment interventions to facilitate the older person to maximise their functional independence / potential, or adapt / compensate for functional deficits. The goal of treatment is to prevent and minimise functional disability and to ensure a safe and successful discharge to home from hospital. OT thus promotes older / frail adults to lead a meaningful life within their community.

Studies demonstrate that occupational therapy intervention improves the quality of life for older adults using a variety of indicators, including physical health, mental health, social well-being and life satisfaction (Clarke, June 2011). This intervention was also cost effective compared to other interventions. Research demonstrates that early intervention by OT within an acute care setting can reduce length of stay (Sutton, 1998) and facilitate early discharge (AOTA, 2012). Occupational therapy falls prevention programmes have been found to prevent and significantly reduce falls among older persons at risk (Close, Ellis, Hooper, Glucksman, Jackson & Swift, 1999; Cumming, Thomas, Szonyi, Salkeld, O"Neill, Westbury et al, 1999; Tolley & Atwal, 2003: Pardessus et al. 2002).

Speech and Language Therapist

The role of the speech and language therapist (SLT) working in the care of the older person involves assessment, treatment and management of any older person with communication and/or swallowing difficulties (dysphagia). Following communication assessment, the SLT makes appropriate recommendations and care-plans e.g. direct therapy and/ or indirect therapy such as advice to family and the MDT. Appropriate management of dysphagia by speech and language therapists can reduce complications and length of stay in hospital. It also reduces morbidity, mortality and improves quality of life. *(RCSLT 2009)"*

Medical social work with older people

In hospital, social work with older people aims to improve/maintain the quality of life of the older person and their families by promoting social and emotional well-being. It achieves this by building on the strengths of the older person and his/her family to maximise their capabilities. In realising these outcomes, social workers work with individuals, families and groups. Social work works as part of the multi-disciplinary team.

Social work uses psycho-social assessment skills, crisis intervention skills, advocacy skills and counselling skills, amongst others, in providing its services. Social work has particular expertise in the assessment of and responses to the abuse of vulnerable older persons. Hospital social work plays a key role in the discharge planning process via the provision of personal social services at home or long term residential care.

Dietetics/Clinical nutrition services

Dietitians/clinical nutritionists will play a key role in providing the nutritional expertise in the management of older people requiring nutritional support (Enteral & Parenteral) and therapeutic diets e.g. diabetes, CVD, renal impairment, gastrointestinal, dysphagia management. They will also work in partnership with the MDT members and catering services in promoting evidence based practice to identify and implement appropriate strategies to improve individuals‟ nutritional status ie screening and monitoring practices, analysis and development of menus.

Health & Social Care Professional Grading Structure

Clinical Specialist Health and Social Care Professional

The clinical specialist health and social care professional provides expertise into complex patient case management using evidence-based practice and advanced clinical judgement acquired through professional experience. They provide leadership to ensure comprehensive and effective service delivery by developing standards of practice; engaging in research, evaluating outcomes and effectiveness of services; contributing to strategic planning and delivery of services; contributing to a structured process for education and training of health and social care professional , medical and nursing colleagues.

Clinical specialist health and social care professionals support/guide senior and staff grade health and social care professional in developing, providing and evaluating a service with regard to maximising cost-effectiveness whilst ensuring high quality of care.

Senior Health and Social Care Professional

The senior health and social care professional provides advanced assessments and interventions as part of a multidisciplinary team approach. Senior health and social care professionals plan and implement individual and group interventions, discharge, follow up and onward referrals. Senior health and social care professionals have advanced knowledge and experience in working with older people and provide training and support to staff and assistant health and social care professionals;contribute to the development of evidence-based practice; apply research outcomes to improve the delivery of service and ensure best use of resources.

Staff grade Health and Social Care Professional

The staff grade health and social care professional provides assessments and interventions in collaboration with the senior health and social care professional. Staff grade health and social care professional translate research evidence and use it to implement effective interventions; prepare and present appropriate information to the senior health and social care professional to support operational and strategic planning.

The staff grade health and social care professional has profession specific knowledge and skills which contribute to rehabilitation and care of older people

Assistant Health and Social Care Professional

The Expert Group on Various Health Professions (2000) report *"the introduction of Assistant health and social care professional has the potential to provide the very necessary practical support for health and social care professionals in the delivery of an efficient and effective service".*

Assistant health and social care professionals can enhance team skill mix and facilitate extending the scope of practice of all health and social care professionals.

Assistant health and social care professionals, under the supervision of appropriate staff grade, senior and clinical specialist health and social care professionals can support implementation and monitoring of individual and group interventions.

* Refer to discipline specific Competencies.

6.3 Roles and responsibilities referred to by Specialist Geriatric Team (SGT)

Access to other professions from the SGS is on a referral basis, a brief description of some of these roles is below can be found in appendix 2.

6.4 Interfaces with other key players

Key features and links of a Specialist Geriatric Service

- Integration with the General Practitioner, primary care and other care programmes i.e. acute medicine, emergency medicine
- Rehabilitation of Older People
- Acute Medical Care for Older People
- The Older Person in the Emergency Department
- The discharge or transfer of care of frail older people for community health and social support
- Collaboration between Geriatricians and Psychiatrists of Old Age
- Comprehensive assessment for the older frail patient in hospital
- Integration of all service providers including housing / voluntary / private sector
- The specialist health needs of older people outside an acute hospital setting
- Geriatric (Medical) Day Care Hospitals for older people
- Assessment of Older People for Continuing Care
- Palliative care

- Geriatricians and management of long term conditions
- Abuse of Older People
- Hospital Discharge of Older People with Cognitive Impairment to Care Homes
- Parkinson"s disease
- Falls
- Continence Services
- Stroke
- Ortho-geriatrics
- Other Specialist Services - Pressure Sores, Pain,
- Medication management

6.5 Location of the team

The team should have a designated physical space (that could act as a point of access) in the acute hospital. The provision of the dedicated space for the team, (a day hospital facility to the base team, carry out the assessments and coordinate the service) will likely require a capital investment for each hospital providing such a service.

Much of the necessary ward space required for patients can be designated from existing resources as it would just require reconfiguration.

6.6 Size of team for acute ward

The practicalities of delivery of this service will vary from region to region and will need to be flexible as the age demographic, acute bed, community and long term residential care needs vary from region to region.

The *NCPOP* will perform a population resource estimation process based on census 2010 data. This document will be updated once the data is made available.

Recommended staffing levels assuming basic ward nursing staffing levels exist are as follows;

Specialist Geriatric Ward *20 bed acute unit*

Nursing	1 WTE = Clinical Nurse Specialist
Physiotherapy	2 WTE = 1 Senior Grade 1 Staff Grade
Occupational Therapy	2 WTE = 1 Senior Grade 1 Staff Grade
Dietetics	1 WTE = 1 Senior Grade
Speech and Language Therapy	1 WTE = 1 Senior Grade
Medical Social Worker	1 WTE = 1 Senior Grade
Podiatry	0.2 WTE

Clerical support and discharge planning are core team requirements for SGT.

Access to pharmacist, psychiatrist and others as appropriate. Skill mix is essential but the compliment will be determined by local site needs. All disciplines should be

included for an effective multidisciplinary team and have access to medical social work, assistant therapy grade staff, clerical support, ICT and other services where indicated.

Inpatient Rehabilitation

The provision of staffing for inpatient rehabilitation is site specific. Recommended staffing levels are outlined in section 6.2.8.

6.7 Bed Capacity Planning

The number of recommended beds varies:

Acute and Rehabilitation Assessment beds [Specialist Geriatric ward]:

- "The Years Ahead" recommends 5.5 beds per 1000 over 65 years [2.5 acute assessment plus 3 rehabilitation]
- The British Geriatrics Society (BGS) recommends 10/1000 over 65 years and 22/1000 over 75 years.
- Modeling of bed capacity can be done using various methods but all will produce different results. The national programme has modeled bed capacity requirements an acute specialist geriatric ward for the "frail Eldelry" cohort of patients in the following way;
    - The total emergency admission for >70s sourced from HIPE for 2010 and a estimated cohort of 24% who are "frail". The median length of stay of 18 days is used calculated as follows;
        - # frail (24% of >70 ED admissions) x 18 days/ 365
    - It is estimated that 36% of these patients will require an extended rehabilitation period of between 4 to 6 weeks which is calculated as follows;
        - # patients x LOS/ 365
- Whilst the national frailty numbers equate to 24 % of total >70 emergency admissions this could be taken as 20% of all >70 admissions and locally this may vary between 15% and 25%.

Long term residential care beds

The HSE Corporate Plan 2011 to 2013 states:

„In line with our strategic direction driven by the „Towards 2016 Social Partnership Agreement" and the new Office for Older People (which was established in January 2008), and in the context of the development of a "National Strategy for Positive Ageing", we are aiming to ensure that a maximum of 4% of the older population will require long term residential care by 2013. This requires focusing on the ongoing development and provision of quality services in the community.'

Therefore, 4% of the > 65 population is the 'target' provision - estimated >65 population 520,000 x 4% = 20,800 long stay beds for >65s.

The increasing aging demographic trends will alter the total number of places required.

Day Hospital places

Day hospital on the acute site should be 2/1000 over 65 years and 4.4/1000 over 75 years.

Outpatient places should be on the acute hospital sites but community hospitals may provide outreach services.

The *NCPOP* will perform a demand/capacity analysis for acute specialist geriatric services and align requirements with the Acute Medicine and Surgery programmes to ensure that proposed bed requirement are not double counted and agreed within medical/surgical stock.

6.8 Guidance on service hours and staffing

Over the coming years, the population will continue to grow and age and other factors such as the rising prevalence of chronic diseases will increase demand for services. At the same time, the numbers working in the health services will decrease. Against this background of reduced budgets and workforces, the challenge is not only to maintain the level, quality and safety of services but to expand the range of services that can be easily accessed by patients in their own communities.

The proposed model of care aims to improve quality and efficiency of care for older people with complex health care needs and for the frail older person. The Specialist Geriatric Team (SGT) will provide a service over an extended day (8 a.m. to 8 p.m. Monday to Friday).

To achieve this, maximum local flexibility will be required to roster staff to meet service needs. Rosters will be designed around patient and service need to provide efficiencies in the utilisation of skill mix, with redeployment of staff if necessary to meet service needs.

Local implementation will require involvement by the service management team (Clinical Director and Programme Lead Clinician, Director of Nursing and Midwifery, Therapy Managers or Heads of HSCP‟ and Chief Executive Officer /General Manager). Consideration of services, location, resources, patient throughput, care and dependency levels, and patient/clinical outcomes will support the determination of staffing i.e. the right number, mix and distribution of the skills, competencies and capabilities required.

7 Corporate and Clinical Governance

7.1 General Principles

Governance of the Specialist Geriatric Services will be organised and delivered in accordance with the recommendations of the Health Information and Quality Authority Draft National Standards for Patient Care 1 and the HSE guidance Achieving Excellence in Clinical Governance, Towards a Culture of Accountability 2010.

To assist healthcare providers a suite of ten principles for good clinical governance, for the Irish health context, were developed with a title and descriptor. The principles developed by an interdisciplinary working group were reviewed for comprehensiveness, clarity and usefulness by health mangers, clinical directors, senior nurses and midwives, health and social care professionals and patient groups. It is proposed that the principles inform each action and provide the guide for mangers and clinicians in choosing between options. It is recommended that each decision (at every level) in relation to clinical governance development be tested against the principles set out in Appendix 7.

The National Programmes are part the Clinical Strategy and Programmes Directorate which was established to improve and standardise patient care by bringing together clinical disciplines and enable them to share innovative solutions to deliver greater benefits to every user of HSE services. On implementing the Acute Model of Care for Specialist Geriatric Services it will be responsibility of the regional director of operations and acute hospital sites to integrate delivery and programme specific performance measurement processes into their core operating functions.

The National Directorate for Older People has a service delivery function to support older people to remain independent, in their own home, or within their community environment for as long as possible. This is achieved through the provision of home and community-based support services (including home help services, home care packages, respite care, day care, meals on wheels, health promotion initiatives / programmes, etc). Where this is no longer possible, we support older people in long term residential care under the Nursing Homes Support Scheme (NHSS). The National Directorate for Older People will maintain their existing governance responsibilities and accountabilities for delivery of services to older people in the community and in their homes and will be responsible for measurement of performance against their targets as set out in the NSP 2012.

7.2 Governance Structures

7.2.1 National Clinical Programme for Older People Steering Group

The steering group includes the National Director for Clinical Strategy and Programmes, the RCPI/ISPGM Clinical Advisory Group, HSE National Directorate for Older Persons and Regional Directors of Operations, Department of Health, Special Delivery Unit.

7.2.2 National Clinical Programme for Older People Working Group

The working group will develop solutions to improve the quality, access and cost of clinical services for older people in line with the objectives set out by the National programme. The Working group will work with the Dept of Health and HSE Directorate for Older Persons to ensure that solutions being developed are in-line with strategy. The working group will develop measurement tools to assist in monitoring progress of implementation of the clinical programme against targets until such time as the model is operationalised and a sustainable governance structure for managing performance of the solution is embedded within the, hospitals, HSE and corporate performance structures.

7.2.3 Local Specialist Geriatric Service Groups

The Specialist Geriatric Service governance group should be chaired by a consultant geriatrician or a designated member of the multidisciplinary team.

The membership of the group is the multidisciplinary team.

1. A representative from the appropriate community care area teams
2. A General Practitioner
3. The group must have a direct link with hospital management.
4. The group should be patient focused and have a clear and documented purpose and terms of reference.
5. Meetings should commence with sign off of minutes of previous meeting and any associated action lists.
6. The agenda should be well organised and issued ahead of any meeting, allowing suitable time for committee members to appraise themselves of the agenda and any associated papers etc.
7. The terms of reference must be reviewed every year or sooner if necessary.

7.2.3.1 Clinical Governance Processes: key responsibilities of the Group:

At every meeting the following should happen:

- Risk management and patient safety items must be addressed at every meeting.
- Clinical reports from each department, e.g. OT report
- Planning, consultation, service provision and service development
- Review of agreed KPIs which should include clinical outcomes as well as outputs

The group must address the following items, at a minimum, quarterly.

(i) Communication and consultation

- Receive assurance from service users and stakeholders that there is clear communication and consultation with its stakeholders.
- Develop an multidisciplinary team approach to the management of all clinical issues.

(ii) Accountability

- Receive assurance from staff that the responsibility, accountability and authority for key clinical end-to-end processes are clear with specific measures and targets against which process performance will be tracked.

(iii) Capacity and capacity planning

- Define and make recommendations to the GM/CEO/CD on clinical priorities
- Identify and implement cost savings initiatives.

(iv) Policies, procedures, protocols and guidelines

- Adopt (from national guidance documents) and monitor implementation of care pathways, care bundles and patient information.

(v) Monitoring and review

- Review key performance measures. In the case of service underperformance or clinical risk, agree actions, allocate responsibility and track progress of actions.
- Identify issues relating to specific clinical service underperformance and progress in accordance with hospital policy via clinical governance committee.

(vi) Clinical effectiveness and audit

- Develop and/or implement an annual clinical audit forward plan as part of the annual planning and delivery cycle for clinical audit activities.
- Ensure accurate recording of data in relation to the episode of care

(vii) Patient/service user and GP involvement

- Engage in structured format with service users with a focus on ongoing service improvements.

(viii) Risk management and patient safety (standing item, every meeting)

- Ensure incident management is occurring in accordance with agreed policy.
- Review the management of incidents, the analysis of the root cause of incidents and the implementation of corrective action.
- Review risk register and track actions.
- Develop, implement and monitor patient safety initiatives around critical areas e.g. medication errors, thromboprophylaxis and management of deteriorating patients.
- Review complaints and ensure they are managed effectively and in line with hospital policy.

(ix) Staffing and staff management

- Receive assurance and make recommendations regarding performance management and continuing professional development processes as they are developed.
- Specialist Geriatric Team members will be dedicated to the specialist geriatric service who will manage the clinical case load. SGT team will clinically accountable to the specialist geriatric service with professional accountability to the existing organizational professional structures for their discipline.

8 Education

Continuing education, training and up-skilling of all groups is recommended as per continuing professional development requirements.

8.1 Medical education

Any appropriate medical and surgical specialty training programme should have as a requirement a defined module in care of the frail older person incorporated in their training.

Given the critical role that General Practitioners play in the care of older people in the community a course such as the Diploma in Elderly Medicine (currently run by RCPI) or an equivalent should be an integral component for those who will be caring for this patient group in the community.

A new specialist training scheme in acute medicine will be developed in conjunction with the Royal College of Physicians of Ireland and the Irish Committee on Higher Medical Training (ICHMT). This will provide training in the specialty of acute medicine only or acute medicine and another specialty e.g. Geriatric Medicine/respiratory/gastroenterology/etc.

Any specialist who is taking on responsibility for unselected medical take in the ED, AMU or hospital, training should have a minimum of one year training in geriatric medicine.

There will be an emphasis on a collaborative approach to education and training; the specialties of emergency medicine, acute medicine, critical care medicine and geriatric medicine should collaborate on relevant aspects of medical education and ongoing professional development, to train and support doctors working in these specialties to provide patients with the highest possible standards of medical care.

8.2 Nurse Education

An experienced, dedicated nursing team with the skill sets and competencies in caring for the frail older person patient is required to ensure the highest quality of care. Nurses need to be equipped with management and leadership skills to support a culture of ongoing education, training, practice and professional development. This should encompass training on the comprehensive geriatric assessment and management of patients, the recognition of the patient with complex needs and the promotion of appropriate care and training in the application of older person care guidelines.

Postgraduate Education / Continued Professional Development

Enhanced nursing roles are of critical importance to support the implementation of the Specialist Geriatric Service – model of care. Development of nursing practice should be in the context of multi-disciplinary, multi-skilled teams. National, regional and local guidelines and frameworks should provide the process and clinical standards required for best

practice by all members of the multi-disciplinary team. Guidance on enhanced nursing roles, for example Registered Nurse Prescribers is contained in the *Scope of Practice Framework* (An Bord Altranais 2000a), the *Code of Professional Conduct* (An Bord Altranais 2000b) and in The *Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Care* (DoHC 2011)

Advanced Nurse Practitioner (ANP)

Nurses and Midwives Act 2011 has given An Bord Altranais responsibility to accredit Advanced Nurse Practitioner (ANP) posts. To be eligible to apply for registration as an ANP, the nurse will be educated to master‟s degree level (or higher). The educational preparation must include a substantial clinical modular component(s) pertaining to the specialist area of practice.

The nurse must have a minimum of 7 years post-registration experience, which will include 5 years experience in the chosen area of specialist practice, and have substantive hours at supervised advanced practice level.

Clinical Nurse Specialist (CNS)

Nurses who apply for CNS approval must have acquired a level 8 post-registration NQAI qualification (major award) relevant to his/her area of specialist practice.

Staff Nurses (SN)

As part of the continuing education of staff nurses working in Care of the Older person services, it is recommended that a higher diploma in Gerontology has been attained.

Nurse and Midwife Medicinal Product Prescribing

The introduction of prescriptive authority for nurses has contributed to a more efficient health service capable of responding more effectively to patients‟ and clients‟ needs. The nurse or midwife must successfully complete the relevant education programme prior to applying to register in the Division of the Register of Nurse prescribers of an Bord Altranais.

Nurse Prescribing of Medical Ionising Radiation (X-Ray)

The introduction of this expanded practice for nurses is a significant initiative in the Irish health service and will have implications for service users in terms of convenience, cost-effectiveness, improved access to radiology services and simplification of the patient journey.

Health care assistants

Continuing education, training and up-skilling of healthcare assistants is recommended. The recognised qualification for Health Care Assistants is the FETAC (NCVA Level 5) Healthcare Support Certificate.

Continued Professional development

Nurses at all levels have a responsibility to update and maintain their skills and competencies. Continuing professional development programmes and stand alone modules are provided through the Centre"s for Nursing and Midwifery Education (CNME"s) and Higher Education Institute"s (HEI"s) throughout the country.

Undergraduate Nurse Education

The undergraduate degree programme provides the appropriate foundation for nurses to practice following registration, and prepares nurses for on-going continuing professional development and development of further competencies as appropriate.

The undergraduate education process provides nurses with the skills and competencies for modern evidence-based healthcare delivery. The programme consists of a combination of theoretical and clinical instruction and has a gerontology component.

8.3 Education and Training of Health and Social Care Professionals

Experienced and skilled Health and Social Care Professionals make a valuable contribution to the care of older people. Health and Social Care Professionals members of Specialist Geriatric Team must be equipped with the necessary skills and knowledge to support comprehensive geriatric assessment and interventions for older people. These professionals require ongoing education, training, practice and professional development opportunities to continue to promote a culture of evidence based practice and to ensure their ability to respond to the complex needs of older people.

Undergraduate health and social care curricula and pre-professional clinical education should reflect the increasing role that each of these professions will play in the care of the frail older adult into the future. At a postgraduate level, specialisation in rehabilitation and care of older people should be an accepted career pathway, reflected by the availability of postgraduate education and research opportunities.

Clinical Specialist Health and Social Care Professional

Clinical Specialist Health and Social Care Professionals should be supported to engage in advanced education and have significant clinical experience working with older people. Qualification criteria may vary for each profession and may include postgraduate education in the specialist area, experience ranging from a minimum of 4-5 years within the specialty and proven record of clinical / academic achievement including continuing development in their specialist field (HSEA, 2001).

Senior Grade Health and Social Care Professional

As part of a commitment to quality in the care of older people Senior Grade Health and Social Care Professionals should be supported to obtain advanced education in rehabilitation and care of older people(if available for the discipline).

Staff Grade Health and Social Care Professional

Staff Grade Health and Social Care Professionals are required to be educated to a Bachelors degree, or equivalent qualification, recognized by the Department of Health and

Children. Staff Grade Health and Social Care Professionals, as part of a commitment to quality care should be supported to engage in advanced training and professional development in the care of older people. This training can be facilitated by the Senior Grade or Clinical Specialist Health and Social Care Professional.

Assistant Health and Social Care Professional

Ongoing training and development of Assistant Health and Social Care Professionals is recommended and can be supported by the Basic Grade, Senior Grade or Clinical Specialist Health and Social Care Professional. Assistant Health and Social Care Professionals should possess FETAC Level 5 qualification and have completed the specific module for the required discipline.

Continued Professional Development

All Health and Social Care Professionals are required to continuously update and extend their professional skills and competences. Each of the relevant professional bodies provides continuing professional development opportunities for Health and Social Care Professionals. All Health and Social Care Professionals should be supported to participate in these development opportunities. Health and Social Care Professionals should also be supported to engage in formal educational programmes made available from the higher education sector.

8.4 New work practices and approaches to training

Cultural work practice and education and training changes around the provision of an acute floor are critical success factors for the programme. This is likely to be a particular problem encountered in model 4 hospitals, where there is a focus on specialty care. It is pivotal to the success of the programme that there is recognition of the critical importance of senior medical doctors assessing the older frail patients promptly on presentation to the acute floor and committing to providing this service as their work priority during hours rostered to the acute medicine service.

Appropriate continuing medical education (CME) and continuing professional development (CPD) training must be encouraged to promote provision of safe and effective care for the older frailer patients presenting with acute medical problems. Exposure of undergraduate and postgraduate trainees to various components of the acute floor throughout their training is likely to facilitate a culture change.

9 Performance Management

9.1 Minimum Data Set

A minimum data set is being developed for Phase 1 of the CPOP to record data on acute care and inpatient rehabilitation. Each SGS will record data via the HIPE CPOP Portal, enabling the programme data to be merged with the generic HIPE data collected on all patients discharged from acute hospitals.

Data collection for the minimum data set will be performed by the SGT on a daily basis. The SGT coordinator will take the lead in managing data quality, including completeness, but it is envisaged that all members of the MDT will be involved in data capture, performance measurement and continuous improvement.

Most patient level Key Performance Indicators (KPIs) and Performance Indicators (PIs) will be estimated from the data collected via HIPE and HIPE Portal. Implementation tracker and annual surveys will assess organisational aspects of the delivery of care.

9.2 Key Performance Indicators

These KPIs relate to care in SGWs and further detail about them is presented in Appendix 3 - Key Performance Indicators. See also section 10.3 (PIs) which capture more detailed information about structure, processes and outcomes of care.

9.2.1 KPI 1: Patient access and throughput in SGWs

KPI 1.1 The number of patients admitted to an SGW: total aged ≥ 65; number aged 65-79, aged ≥ 80 years

KPI 1.2 Percentage of patients admitted to an SGW directly from ED or within 2 days of hospital admission who have been discharged before day 19 in the SGW

KPI 1.3 Percentage of patients admitted to an SGW after 3 days or longer in other wards in the hospital who have been discharged before day 19 in the SGW

Rationale: This KPI aims to track progress in developing capacity in SGWs, to monitor access to specialist geriatric inpatient care and to monitor length of stay in SGWs (see also KPI2). There is evidence that outcomes are better for older patients with complex care needs who are treated in SGWs compared to those who receive acute care in general wards. Coordinated multidisciplinary care is planned and started in the SGW. If patients require ongoing rehabilitation or are likely to have greater care needs when discharged compared to when they are admitted, this will be planned soon after admission, to support timely discharge from the SGW.

9.2.2 KPI 2: Length of stay in Specialist Geriatric Wards

KPI 2.1: For all patients admitted to a SGS and discharged alive: median length of stay in the SGW (a) before and (b) after clinically fit for discharge

KPI 2.2: For patients newly discharged to long term residential care: median length of hospital stay (a) before and (b) after Common Summary Assessment Report (CSAR) submitted

Rationale: The SGS aim to reduce length of stay in beds designated for acute geriatric care. This is reflected in length of stay before patients are clinically fit for discharge and date by which CSAR is completed. Length of stay after these dates reflects effectiveness of discharge planning by the SGS but is also dependent on access to services which are usually not managed by these services, vis. home care packages, offsite rehabilitation, decisions re eligibility for financial support for long-term care and access to long-term care.

9.2.3 KPI 3: Outcomes after Hospital Care in Specialist Geriatric Ward

KPI 3.1: Percentage of those admitted to or transferred into an SGW who are newly discharged to long term residential care

KPI 3.2 Percentage of those admitted to or transferred into an SGW who are alive and at home (a) 6 months and (b) 12 months after discharge

Rationale: Important aims of the SGS in the acute hospital are to improve functional outcomes and to reduce the percentage of patients discharged to long term residential care. These aims are consistent with evidence that patients receiving specialist care are more likely to be alive and at home 6 and 12 months after specialist inpatient care compared to similar patients cared for in general medical wards.

9.3 Performance Indicators

These PIs reflect implementation of SGS in the acute setting as covered by this component of the Model of Care (Part 1). Additional PIs will be put in place with expansion of services in other care locations to be addressed in the Model of Care (Part 2).

Some of the PIs relate to capacity and efficiency of other services apart from the specialist geriatric services e.g. to put home care packages in place or to access long term residential care.

9.3.1 Group 1 - Geriatric Facilities and Staff

Baseline and annual surveys to record:

A Number of beds in SGWs
B Number of specialist geriatric rehabilitation beds (on site of acute hospital and offsite)
C Number of transitional beds for discharges to long term residential care aged ≥ 65
D Number of beds in publicly funded facilities for short term and long term residential use, by designation e.g. rehabilitation, respite, long term residential care
E Multidisciplinary team (MDT) whole time equivalents by profession and grade in acute and community facilities for older people
F Care protocols implemented

G Education and continuing professional development

9.3.2 Group 2 - Inpatient Care in SGW

1 Throughput and Processes of Care

A Number of patients admitted to an SGW (see KPI 1)

B Assessment by SGT within 5 days of admission

C Length of stay before first discussion of rehabilitation and discharge plan with patient and carer

D Length of stay before and after clinically fit for discharge from SGW (KPI 2)

E If discharged home: length of stay before and after home support request submitted to community services

F Number of patients discharged home with a supported discharge package

G Number of patients who received inpatient rehabilitation in a designated rehab bed

H Length of stay in the SGW before transfer to onsite or offsite dedicated rehab bed

I Length of stay before and after CSAR submitted (KPI 2)

J If going to LTC via transitional bed: length of stay before and after transitional bed requested

K Timing of information re discharge going to GP and primary care

2 Outcomes

A Barthel score at 'clinically fit for discharge' milestone

B Discharge location: The programme aims to reduce the percentage newly discharged to long term residential care (KPI 3)

C Return to ED: number and % who had been inpatients in SGW returning to the ED within 28 days of discharge from hospital

D Number and percentage of emergency readmissions after inpatient stay in SGW ;

- Emergency readmission is an unscheduled admission following previous spell of treatment in the same hospital and relating to the treatment or care previously given (HIPE definition)

E Percentage of those admitted to or transferred into an SGW who are alive and at home (a) 6 months and (b) 12 months after discharge (KPI 3)

9.3.3 Group 3 - Offsite rehabilitation

A Number of patients admitted to an offsite rehabilitation unit from SGS within 48 hours of referral

B % of patients assessed by MDT within 5 days of admission

C % of patients with length of stay in offsite inpatient rehabilitation of < 42 days

D Average and median length of stay in offsite rehabilitation unit

E Number of patients discharged:

- home with a supported discharge package
- home without a supported discharge package
- to LTC

F Length of stay before and after CSAR submitted

G If going to LTC via transitional bed: length of stay before and after transitional bed requested

H Timing of information re discharge going to GP and primary care

9.3.4 Group 4 - AMU/AMAU/ Short Stay unit/medical wards

A Number of patients ≥ 65 years (a) seen as consult and (b) who receive CGA by the SGS in AMU / AMAU / short stay unit / medical ward

B When discharged, results of SGS to GP

9.3.5 Group 5 - Non-admitted Patients and Outreach

A Number of patients (a) seen as consult and (b) who receive CGA by the SGS by location: emergency department (ED), DH, long term residential unit, home or other community location

B Percent of patients (in settings other than the ED) receiving a CGA within 4 weeks of referral

9.4 Audit and Review

A baseline survey of services (facilities, staff and processes of care) will be performed and annually thereafter to assess the infrastructural and organisational performance indicators. HIPE and HIPE portal will be used to collect and report on performance through the ESRI self service reporting tool. Each site will be required to put in place the necessary mechanisms to collect the data to an appropriate quality.

9.5 Performance Reporting

In line with national clinical care programmes reporting system the implementation checklist for the NCPOP will be required to be completed and returned by each of the sites implementing the model of care. These plans will form the baseline plan/timeline for implementing the model. Regular updates will be required from each of the sites on a weekly, monthly or quarterly basis.

It is essential that targets for the PIs are agreed with each site to ensure that the maximum benefits outlined in the business case / benefits plan are achieved.

In so far as possible the NCPOP has aligned the minimum data set to the KPIs and PIs described, thus reducing potential duplication in the performance reporting function. Data will be captured on a continuous basis and reviewed weekly in the early stages of Programme implementation. This period will be extended to monthly, bi annual and annual as the programme becomes ingrained in the services and outcomes are demonstrable.

10 References

Ahmed NN, Pearce SE (2010). Acute care for the elderly: A literature review. Population Health Management, 13(4), 219-225

Alzheimer‟s Society UK website: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=341

American Occupational Therapy Association (AOTA) (2012) „Occupational Therapy‟s Role in Acute Care‟ The American Occupational Therapy Association Bethesda: AOTA

An Bord Altranais (2000) Code of Professional Conduct for each Nurse and Midwife. An Bord Altranais, Dublin

An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework. An Bord Altranais, Dublin.

Asmus-Szepesi KjE, de Vreede PL, Nieboer AP, et al (2011). Evaluation design of a reactivation care program to prevent functional loss in hospitalised elderly: A cohort study including a randomised controlled trial. BMC Geriatrics, 11:36 doi:10.1186/1471-2318-11-36

Bachmann S, et al. (2010). Inpatient rehabilitation specifically designed for geriatric patients: systematic review and meta-analysis of randomized controlled trials, BMJ, 340:c1718.doi:10.1136/bmj.c1718

Baztan JJ, et al. (2009). Effectiveness of acute geriatric units on functional decline, living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis, BMJ, 338:b50 doi:10.1136/bmj.b50

Black D (2005). The geriatric day hospital Age and Ageing . 34:427-429.

BMC Health Services Research Dec 30(8): 278

Cameron I, Stafford B, Cumming R (2000). N Hip protectors improve falls self-efficacy‟, Age Ageing 29: 57-62.

Campbell AJ, Robertson MC, La Grow SJ et al (2005). Randomized controlled trial of prevention of falls in people aged > 75 with severe visual impairment: the VIP trial. BMJ, 331&7520), 817-820

Clemson L, Cumming RG, Kendig H, et al (2004). The effectiveness of a community-based program for reducing the incidence of falls in the elderly: A randomized trial. Journal of the American Geriatrics Society, 52(9), 1487-1494

Courtney M (2009) Fewer Emergency Readmissions and Better Quality of Life for Older Adults at Risk of Hospital Readmission JAGS 57 (3): 395-402

Covinsky KE, Palmer RM, Fortinsky RH, et al (2003). Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age, Journal of the American Geriatric Society, 51(4), 451-458

Cumming R, Thomas M, Szonyi G (1999). Home visits by an occupational therapist for assessment and modification of environmental hazards: a randomized trial of falls prevention‟, Journal of American Geriatric Society 47: 1397-1402.

Cusick A, Johnson L, Bissett M (2009). Occupational therapy in emergency departments: Australian practice‟, Journal of Evaluation in Clinical Practice 15(2): 257-265.

Daniels R (2008). Interventions to prevent disability in frail community-dwelling elderly: a systematic review

De Morton (2007). Exercise for acutely hospitalised older medical patients. Cochrane Database of Systematic Reviews 2007;Issue 1

Department of Health and Children (2011) Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Care. Department of Health and Children, Stationery Office, Dublin.

Ellis G et al (2011). Comprehensive geriatric assessment for older adults admitted to hospital. The Cochrane Database of Systematic Reviews doi10.1002/14651858.CD006211.pub2

Forster A (2010). Is physical rehabilitation for older people in long-term care effective? Findings from a systematic review Age and Ageing 39(2):169-175

Gitlin L, Corcoran M (2005). Occupational Therapy and Dementia Care: The Home Environmental Skill-Building Program for Individuals and Families, Bethesda (MD): AOTA Press.

Gitlin L, Corcoran M, Winter L, Boyce A, Hauck W (2001). A randomised controlled trial of a home environmental intervention: effect on efficacy and upset in caregivers and on daily function of persons with dementia", Gerontologist 41: 4-14.

Gitlin L, Reever K, Dennis M, Mathieu E, Hauck W (2006). Enhancing quality of life of families who use adult day care services: short and long term effects of the adult day services plus program", Gerontologist 46: 630-639.

Government of Ireland, House of the Oireachtas (2011) Nurses and Midwives Act (Number 41 of 2011)

Graff MJL, Adang EMM, Vernooij-Dassen MJM, et al (2008). Community occupational therapy for older patients with dementia and their care givers: cost effectiveness study. BMJ, 336(7636), 134-138

Graff M, Vernooij-Dassen M, Thijssen M, Dekker J, et al (2006). Community based occupational therapy in caregivers of patients with dementia and their caregivers: randomized controlled trial", British Medical Journal 333: 1196.

Graff M., Vernooij-Dassen M, Thijssen M, Dekker J, et al (2007). Effects of community occupational therapy on quality of life, mood and health status in dementia patients and their caregivers: a randomized controlled trial", The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 62: 1002-1009.

Graff MJL, Vernooij-Dassen MJM, Thijssen M, et al (2006). Community based occupational therapy for patients with dementia and their care givers: randomised controlled trial. BMJ, 33, 1196-1199

Hart D, Bowling A, Ellis M, Silman A (1990). Locomotor disability in very elderly people: value of a programme for screening and provision of aids for daily living", British Medical Journal 301: 216-220.

Heywood F, Turner L (2007). Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence. London: Her Majesty"s Stationery Office

Hill S (2007). Independent living: Equipment cost savings. (report to the College of Occupational Therapists)

Hse Code of Practice for Integrated Discharge Planning (2008)

HSE Dublin South City, Community Rehabilitation Team (2009) Audit of the Effectiveness of Community Therapeutic Rehabilitation Intervention

HSEA HR Circular 10/05/01 re Creation of Clinical Specialist Posts Therapy Professions:

http://www.hse.ie/eng/staff/Resources/HR_Circulars/Creation%20of%20Clinical%20Specialist%20Posts%20Therapy%20Professions.pdf. [Accessed 21 June 2012]

Law M, Steinwnder S, Leclair L (1998). Occupation, health and well-being", Canadian Journal of Occupational Therapy 65(2): 81-91.

Lewis D, Editor (2008). Organization design for geriatrics: an evidence based approach. Canada: Toronto. Regional Geriatric Programs of Ontario

Liddle J, March L, Carfrae B, et al (1996). Can occupational therapy intervention play a part in maintaining independence and quality of life in older people? A randomised controlled trial", Australian and New Zealand Journal of Public Health 20: 574-578.

McCusker J, Bellavance F, CardinS, et al (1999). Detection of Older People at Increased Risk of Adverse Outcomes After an Emergency Visit: The ISAR Screening Tool. Journal of American Geriatrics Society. 47(10), 1229-1237.

National Council for the Professional Development of Nursing and Midwifery (2008a). Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts Intermediate Pathway 4th edn. NCNM: Dublin.

National Council for the Professional Development of Nursing and Midwifery (2008b). Framework for Establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts, 4th edn. NCNM: Dublin.

National Council for the Professional Development of Nursing and Midwifery (2008c). Accreditation of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts, 2nd edn. NCNM: Dublin.

Ontario Hospital Association (2003). Geriatric Emergency Management (GEM): An Overview of Delivery Models, Screening Tools and Practice Guidelines. Available at http://rgp,toronto.on.ca/GEM/GEMOHA.pdf (accessed September 2011).

OTN (April, 2010) Somerset Council report on reduction of double handling. London: College of Occupational Therapy.

Pardessus V, Puisieux F, Di Pompeo C, et al (2002). Benefits of home visits for falls and autonomy in the elderly: a randomized trial study", American Journal of Physical, Medicine and Rehabilitation 81: 247-252.

Peiris CL (2011). Extra physical therapy reduces patients length of stay and improves functional outcomes and quality of life in people with acute and subacute conditions: a systematic review. Arch Phys Med Rehabil 92(9): 1490-500

Riverside Community Health Care NHS Trust (1998) The Victoria Project: community occupational therapy rehabilitation service: research findings and recommendations. London: Riverside Community Health Care NHS Trust.

Sreultjens E, Dekker J, Bouter L, Jellema S, et al (2004). „Occupational therapy for community dwelling elderly people: a systematic review", Age and Ageing 33: 453-460.

Sutton S (1998). An acute medical admission unit: Is there a place for an occupational therapist? British Journal of Occupational Therapy, 61(1), 2-6.

Theou O (2011). The effectiveness of exercise interventions for the management of frailty: a systematic review Journal of Aging Research 4:569194

Wade D (2007). Challenging assumptions about rehabilitation. Clinical Rehabilitation, 21, 1059-1062

Wells L J, MD, Seabrook Jamie A, MA, Stolee Paul, PhD, Borrie Michael J , MB, ChB, Knoefel Frank, MD (2003b). State of the Art in Geriatric Rehabilitation. Part II: Clinical Challenges

Wells L J, MD, Seabrook A Jamie, MA, Stolee Paul, PhD, Borrie Michael J, MB, Chb, Knoefel Frank, MD (2003a) State of the Art in Geriatric Rehabilitation. Part I: Review of Frailty and Comprehensive Geriatric Assessment

Young H (2003). Challenges and solutions for care of frail older adults. Online Journal of Issues in Nursing. 8(2) Manuscript 4. Available at: http://www.nursingworld.org/ojin/topic21/tpc21_4.htm (accessed 27 April 2006).

11 Appendix 1- The ISAR Tool

THE IS.AR TOOL:
Initial Screening Questionnaire

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PLEASE ANSWER YRS OR NO TO EACH OF THESE QUESTIONS

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2011/02 Version

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12 Appendix 2 – Roles of the Specialist Geriatric Team

12.1 Business manager

A business manager is essential for the efficient running of the service, particularly in organising and facilitating prompt access to investigations and treatment within the hospital and also negotiating the primary/secondary care interface in both directions.

The roles of the business manager are:

- To oversee service delivery within the department
- To manage and oversee good use of space, time, specialist input
- To promote patient friendly service delivery
- To promote cost efficient service delivery
- To negotiate budgets and service level agreements
- To draw up business cases
- To advise on resource use, allocation and availability

12.2 Specialist Nursing (ANP/CNS)

The specialist nurse focuses on assessing and promoting the health and function of frail older people, assisting them in preventive and rehabilitative processes. Clinical involvement encompasses a continuum of care for frail older people, extending from their well being health needs through to the acute and chronic illnesses as they are manifested in later life. The roles of the CNS and the ANP are distinguished by their scope of practice, the educational preparation required and their levels of clinical decision-making, responsibility and autonomy. (ABA 2000)

12.2.1 Advanced Nurse Practitioner

The Advanced Nurse Practitioner will:

- Carry out comprehensive geriatric assessment and/or specific health and other related assessments and diagnostic procedures
- Prescribe and provide appropriate treatment, care and interventions in response to frail older peoples" identified needs
- Provide nurse led clinics in conjunction with the SGT to formulate future care and treatment plans (e.g. falls assessment, memory clinics)
- Actively promote the liaison and co-ordination of services and referral processes for frail older people between hospital and community
- Manage the Older Persons Register, keeping an up-to date monthly account of service statistics that will include data on referrals, total number of patients seen, age, LOS, discharge destinations, mortality and OPD numbers to audit and plan services
- Lead innovations in clinical, nursing, health and related care practice in order to enhance standards of care
- Facilitate service and multi-professional practice developments based on relevant research, clinical and other audit and educational activity in relation to older persons" specific needs

- Provide new and additional health and related services, in collaboration with other health care professionals in response to identified needs
- Participate in the development and delivery of educational programmes for nursing and other health and social care staff within the organisation and the wider community
- Contribute to the development of performance indicators and monitoring of same within services
- Contribute to annual service reports and service plans in the interests of high-quality care and service provision
- Integrate nursing and other relevant research into clinical, nursing, health and related care practice
- Initiate, co-ordinate and conduct clinical, nursing, health and related research and audit

12.2.2 Clinical Nurse Specialist

The Clinical Nurse Specialist will:

- Work in collaboration with other members of the SGT in assessing, planning, implementing and evaluating an individualised plan of care for frail older people
- Support, advise and help build on the knowledge and expertise of the other members of the SGT involved in providing care for frail older people, through regular formal and informal education
- Act as resource in providing specialist knowledge, expertise and care in liaison with the multidisciplinary team
- Provide specialised nursing care to frail older people, as identified by comprehensive geriatric assessment
- Actively promote the liaison and co-ordination of care for frail older people between services in the hospital and the community
- Implement health promotion strategies in accordance with the public health strategies for care of frail older people
- Enable older persons to participate in decisions about their health and other needs
- Monitor and ensure maintenance of adequate and effective discharge planning for patients returning to their own homes or long term residential care
- Articulate and represent older person‟s interests in collaboration with the multidisciplinary team
- Implement change in health and related services provided by SGT in response to identified needs of the older person
- Identify the educational needs of patients, their carers, other professionals and students and participate in training programmes as required
- Provide mentorship, etc, for other nurses and health care worker colleagues
- Contribute to the development of key performance indicators and monitoring of same within services
- Educate older people and their relatives/carers in relation to their specialised health and related care needs
- Identify and integrate nursing and other evidence into health and related care practice
- Initiate, participate in and evaluate audits of nursing, health and related care practice
- Contribute to policy development and formulation, performance monitoring, business planning and budgetary control
- Provide leadership in clinical, nursing, health and related care practice
- Generate and contribute to the development of clinical, nursing, health and related care standards and guidelines

- Use specialist knowledge to support and enhance generalist nursing and multidisciplinary practice

12.3 Health and Social Care Professionals

12.3.1 Physiotherapy

Physiotherapy uses physical approaches to promote, maintain and restore physical, psychological and social wellbeing, taking account of variations in health status. (CSP, 2002). There is clear evidence that physiotherapy as part of a well-designed and multidisciplinary intervention consistently benefits the frail older adult.

Physiotherapy-led interventions are effective in the acute, subacute, community and residential care settings (Forster, 2010; Daniels, 2008). Evidence has shown those interventions can:

- Reduce falls risk and incidence of fracture
- Maintain and improve functional ability including gait
- Promote mental health and well-being
- Reduce length and cost of hospital stay (de Morton, 2007)
- Improve continence (Dumoulin, 2010)

In addition exercise improves cardio respiratory function, muscle function, flexibility, physical activity participation, and functional ability of frail older adults (Theou et al, 2011).

The physiotherapy team takes a holistic approach to patient management and aim to take patients‟ emotional and mental wellbeing as well as their physical needs into account in order to set realistic individual goals.

One of the main aims of physiotherapy intervention in the care of the older person is to optimise mobility and functional capacity. The physiotherapist works as part of the SGT to:

- Identify patients at risk of deterioration
- Identify patients at risk of falls
- Provide specialist assessment and rehabilitation of musculoskeletal, neurological and cardio-respiratory conditions
- Provide individually tailored programmes which may include:
    - Range of motion exercise and strengthening exercises
    - Transfers (e.g. getting in and out of bed, sit-to-stand) and stairs practice
    - Posture re-education
    - Gait re-education
    - Balance training
    - Self management strategies and promotion of independence and confidence in the performance of activities of daily living
- Assess and prescribe medical and surgical equipment and appliances such as walking aids

- Facilitate early discharge planning
- Develop and maintain effective care pathways between the SGT, PCT, acute hospital and other services as appropriate
- Provide education and training to the older person, family members, carers and other relevant professionals, guiding them on how to assist the older person to perform activities of daily living at the maximum level of independence possible and also on the importance of encouraging the older person to comply with physiotherapy exercise programmes.

12.3.2 Occupational Therapy

Occupational Therapy is as a profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation." (WFOT)

Occupational Therapists (OT) use physical, cognitive, psychosocial and psychological approaches to assess, promote, maintain and restore physical, psychological and social wellbeing.

Research demonstrates the benefits of occupational therapy interventions in all settings, from the Emergency Department, to acute care in patient, to discharge planning and the home environment, for frail older adult (Cusick et al. 2009: Sutton, 1998: AOTA, 2012).

Occupational Therapy:

- Promotes health and well-being through the use of occupation (Law et al. 1998)
- Is effective in decreasing falls in older people who are at high risk of falling (Cumming et al. 1999; Pardessus et al. 2002)
- Improves physical health, mental health, social well-being and life satisfaction (Clarke, 2011)
- Improves the quality of life, mood and health status of both patients and caregivers (Graff et al. 2007)
- Improves functional mobility, self care and home management activities (AOTA 2012)
- Improves the daily functioning of older people with dementia and their caregiver"s sense of competence (Graff et al. 2006)
- Is effective in decreasing falls in older people who are at high risk of falling (Cumming et al. 1999; Pardessus et al. 2002)
- Significantly reduces, when based in the ED to screen older people and address unmet functional needs, the number of older people being readmitted back into the acute setting (Cusick et al. 2009)
- Provides training in self-care activities to the older person using adaptive medical equipment and/or compensatory techniques if required (AOTA, 2012)
- Remediates upper-extremity weakness and/or abnormal muscle tone through exercise relevant simulated activities (AOTA, 2012)

- Prescribes / fabricates customised splinting to preserve muscle balance and range of motion (AOTA, 2012)
- Uses neuromuscular re-education, trunk stabilisation, and balance activities to improve clients" ability to perform self-care and home management activities (AOTA, 2012)
- Assess and prescribe medical and surgical equipment and appliances such as wheelchairs, hoists and assistive technology which are deemed essential in supporting the older person at home (HSE Provision of Equipment of Aids and Appliances to Designated Care Units, 2011)
- Develop home programmes and instruct older people, family members and caregivers in how to use the programmes to continue rehabilitation after discharge (AOTA, 2012)
- Focuses on increasing or maintaining functional independence, social participation and quality of life, both from a preventative perspective and a treatment perspective (Steultjens et al. 2004)
- Reduces length of stay within the acute setting (Sutton, 1998) and facilitates early discharge (AOTA, 2012).

The Occupational Therapist is trained to match the older person"s needs and abilities to their environment which ensures a successful transition from the acute hospital to the home, community or new care environment. The Occupational Therapist plays a key role in the safe and successful discharge of patients. Safety / hazards assessment by an Occupational Therapist is effective in increasing functional ability (Cameron et al. 2000; Hart et al. 1990; Liddle et al. 1996), reducing risk of falls (Cumming et al. 1999; Pardessus et al. 2002; Gitlin et al. 2006) and reducing the risk of early readmission.

The Occupational Therapist addresses all components and performance areas of an individual"s *everyday life* to enhance their occupational / functional participation. Within the programme for Older People the Occupational Therapist in the Specialist Team for Older Persons addresses the following:

1. The client"s performance areas: activities of daily living, home management, care of others, leisure activities
2. The client"s performance components; sensorimotor, neuromuscular skeletal, motor, cognitive integration and cognitive components, psychosocial skills and psychological components
3. The client"s performance context: temporal aspects and environment.

Occupational Therapy uses specialised knowledge to advocate for and on behalf of the frail / older adult to enhance their ability to engage in activities that they want to, need to, or are expected to do.

12.3.3 Speech and Language Therapy

The role of the speech and language therapist (SLT) working in the care of the older person involves assessment, treatment and management of any older person with communication and/or swallowing difficulties.

Appropriate management of dysphagia by speech and language therapists can reduce complications and length of stay in hospital. It also reduces morbidity and mortality and improves quality of life. *(RCSLT, 2009).*

The SLT"s role includes

- Education provided by SLT to other team members on detection, monitoring and management of clients with dysphagia.
- Education and training of staff to reduce risk. „People with communication difficulties have been found to be 3 times more likely to experience a preventable adverse event" in a hospital setting. *(Bartlett et al, 2008).*
- Providing specific management strategies for patients with dementia can reduce stress and burden on caregivers (RCSLT, 2005).
- Cognitive stimulation therapy groups such as those run by SLT"s in conjunction with other H&SCP"s e.g. OT have been found to have benefits similar to those of some medications. (Spector et al, 2003).
- Contribute to assessment of individuals with mild, or mild to moderate cognitive problems, to contribute to differential diagnosis (Bryan & Maxim, 2006).
- Assessment of decision-making capacity.
- Individual therapy for patients with swallowing or acquired communication difficulties.

Any client with suspected swallowing or communication difficulties must be referred for SLT assessment as early as possible.

12.3.4 Dietitians/Clinical Nutritionists:

Nutrition is embedded in the management of chronic diseases, malnutrition and functional abilities of the older person. Nutrition also plays a preventative role and is identified as a key component of quality of life (Perry & Mc Laren 2004)

The dietitians role with the frail older person encompasses the broad spectrum of nutritional and educational interventions and includes:

- To identify and assess malnutrition risk. Implement appropriate lifestyle and nutritional support strategies with the individual, family and staff.
    - Malnutrition after stroke has been associated with limited response to rehabilitation (Davis et al 2004); increased risk of chest infections due to reduced respiratory muscle function (Arora and Rochester 1982); apathy, depression, fatigue and loss of motivation (Keys et al 1950) leading to lack of willingness to participate in rehabilitation programmes (W.F.R Nip et al 2011). W.F.R et al (2011) found that dietary energy intake predicts rehabilitation outcomes and post-stroke nutritional support should be prioritised to ensure optimal recovery and rehabilitation
- Assess and calculate nutritional requirements for the prescription of oral nutritional supplements, enteral tube feeding and parenteral nutrition; co-ordinate tube feeding arrangements for patient/family/carer.
- Manage existing co-morbidities e.g. diabetes, Cardiovascular Disease, renal impairment, stroke and neurological conditions, cognitive impairment, dementia, bone health.
- Work in collaboration with other MDT members e.g. linking with SLT in the management of dysphagia.

- Provide nutritional advice to catering services on analysis and development of menus and therapeutic diets.
- Educate and support patient, family/carer‟s to maintain nutritional status; implement eating/mealtime strategies for cognitively impaired; advice on lifestyle/social factors impacting on nutritional intake.
- Promote and implement evidence based practice with healthcare professionals, resulting in positive outcomes for patients and health service resources.
    - Malnutrition in >65 years in 43% of hospital patients and 42% in residential facilities in Ireland (BAPEN NSW 2010). Implementation of nutritional screening tools and referral pathways are recommended.
    - Dietetic interventions with healthcare professionals results in more appropriate prescribing practices and a 14.5% reduction in prescribing of oral nutritional supplements (Kennelly et al 2011)
    - Expanding nurses role to replace gastrostomy tubes in long term residential care has shown reduction in acute hospital admissions (HSE Midlands 2005).
    - Review of tube feeding practices in long term residential care sites resulted in estimated savings of €4000 per client per annum in north Dublin (2010).

A structured nutrition and dietetic service results in better outcomes for the frail older person in all care settings as well as cost savings for the service provider.

12.3.5 Social Worker

The primary care social worker working as part of a multi-disciplinary team aims to promote health and well-being, focuses on advocacy, on fostering and empowerment and seeks to encourage self-help in the local community.

Social work in the hospital setting aims to offer a service which ensures that the patient‟s social and emotional needs are addressed alongside the medical treatment they receive and for which they came into hospital in the first place.

At all times, the social worker works with users of the social work service in a manner which allows them to maintain their dignity and self-respect and maximum control over their lives.

The tasks the social worker undertakes include-

1. Social assessment of the older person‟s needs and risks. This includes social support/isolation in their community and ability to perform day-to-day activities
2. Financial and welfare matters, housing difficulties and family/marital problems
3. Mediation and advocacy on behalf of the older person/patient with community/hospital and other service providers and family members regarding (a) the older person‟s right to information, (b) participation in decision-making about treatment and discharge, (c) the right to self-determination (that is, the right to make choices for themselves) and (d) the need to see the patient as a person and not a „case‟
4. Provision of a crisis intervention service
5. Liaison/co-ordination with community and hospital services regarding planning and implementation of future care

6. Working with other social workers in the professional association (IASW) to promote/advocate for the rights of users of social work services and to promote social work
7. Direct work with patients and their families regarding the bio-psychological and social issues related to ill health. Loss, identity, role changes, confusion and anxiety are all significant factors that call for counselling and other intervention

Both primary care social workers and hospital social workers have a role in identifying and preventing abuse of vulnerable adults and can provide intervention in families where domestic abuse, including elder abuse, is suspected or detected.

12.3.6 Orthoptist

Visual impairment in older people is an important risk factor for falls and hip fractures, but is commonly unreported, and often treatable.

Access to orthoptic services, usually done via ophthalmology, is essential in cases of diplopia (double vision) and loss of peripheral vision. Diplopia (5.5%) and hemianopia (14.6%) are frequently the first signs/symptoms in cases of stroke (ref Rathore, Rosamond, Stroke 2002). Failure to recognize and, if possible, treat these conditions, can have a detrimental effect on quality of life.

12.3.7 Podiatrist

Podiatry is the healthcare profession that specialises in the management of diseases and disorders of the lower limb and foot. Podiatry care ranges from nail and skin pathologies to the management of patients with diseases that can compromise the viability of the lower foot and lower limbs and mechanical correction of gait and posture. Podiatry care can make a difference to older people"s mobility and therefore to their quality of life. International research has shown that podiatry care can improve and maintain the mobility of clients.

The podiatrists role in care of the older person is to relieve foot pain, improve foot function and maintain mobility.

Podiatrists have a important role in:

- preventing amputations for those increasing numbers of older persons with diabetes
- preventing falls (there is increasing evidence that foot problems and inappropriate footwear increases the risk of falls)
- Treatment of pressure sores and other foot wounds

12.3.8 Psychiatry of Old Age

Psychiatry of old age (POA) provides specialist mental health services for older people and has specific responsibility for people who develop mental disorders over the age of 65 years. It responds to the needs of two groups of people.

1. Older people developing functional psychiatric disorders such as depression for the first time over the age of 65 years.

2. Dementia sufferers with behavioural or psychological problems for which psychiatric intervention is required.

Specialist psychiatric services specifically for older people are required because:

- Many people become mentally ill for the first time over the age of 65 years, partly because of losses such as bereavement and physical ill health but also because of pathological changes in the brain reflected in the dementias.
- Changing demographic factors with more people surviving to old age and, therefore, more at risk of developing dementia.
- The special needs of elderly people with psychiatric problems. These include increased likelihood of comorbidity i.e. coexisting physical and mental health problems, and atypical presentation of depression in old age.
- The need for identification and treatment of psychiatric and behavioural disturbance in dementia sufferers which may occur in up to 70% of those with dementia and require specialist skills.
- Late onset psychoses requiring specialist psychiatric management.

Psychiatry of old age service must develop in conjunction with geriatric medicine services particularly because of the comorbidity of medical and psychiatric problems in old age. Equally the specialty must be an integral part of psychiatry to ensure that skills in assessing and treating psychiatric disorders and behavioural problems are retained and enhanced by adopting any new treatments developed in psychiatry.

Services are consultant led multidisciplinary teams ideally based in general hospitals with close working relationships with both primary care services, particularly general practitioners and public health nurses, and with geriatric medicine services. Close working relationships between psychiatry of old age and geriatric medicine are best ensured by siting psychiatry of old age services in general hospitals. These should be the base of the team, the site of acute beds, the day hospital and any outpatient clinics. Equally important, close working relationships with general practitioners are critical to ensuring a holistic approach to the care of older people including those with mental health problems.

12.4 Pharmacist

The mission of the pharmacist is to provide pharmaceutical care. Pharmaceutical care is the direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient"s quality of life. In the context of SGS the pharmacists role is to:

- Provide advice to SGT members on medication use in the older person
- Provide guidance on evidence based prescribing e.g. STOPP/START criteria (Screening Tool of Older Person"s potentially inappropriate prescriptions / Screening tool to alert doctors right (i.e. indicated appropriate) Treatment)
- Support audit and training in relation to prescribing practice to ensure that the most appropriate and cost-effective agents are used by the SGT
- Management of pharmaceutical care issues of individual patients

The Clinical Pharmacist will:

- Provide and document medicines reconciliation for older patients assessed by the SGT
- Medicines reconciliation on admission will involve;

    - Collecting a comprehensive pre-admission medication list by speaking to the patent and/or their carer about their medications, and contacting as required and appropriate;
        - the patient‟s community pharmacy
        - the patient‟s GP Surgery
        - the patient‟s nursing home
    - checking of the pre-admission list against the in-patient hospital Kardex
    - Liaison with the lead clinician and the SGT to highlight and resolve any changes, omissions or errors identified during the medicines reconciliation process on admission.
    - Documentation of the medicines reconciliation process and outcomes on a discharge document
- Provide pharmaceutical care to patients during their hospital stay, reviewing patients for key pharmaceutical care issues such as
    - Use of appropriate medication at optimal dosage and form for the individual patient
    - Identification of untreated indications and selection of therapies compatible with the patient‟s clinical status, drug-profile and co-morbidity profile
    - Identification of inappropriate medication use such as
        - improper drug selection
        - adverse drug reactions
        - drug-drug and drug-disease interactions
        - medication use without indication
        - failure to receive medication
        - inappropriate use of/adherence to treatment regimen
- Plan for the discharge of the patient by
    - Ensuring the timely preparation of the discharge prescription, and discharge document,
    - Providing a medicines reconciliation service prior to discharge clearly indicating any changes or discontinuations in medication
    - Counsel the patient/and carer prior to discharge about their medications and discuss and reiterate the importance of adherence to medical therapy.
    - Liaise with the community pharmacist to ensure seamless care for the patient, an unbroken supply of their required medications and ongoing community based pharmaceutical care using the discharge document
- Encourage patient/carer to keep an up to date list of current medications

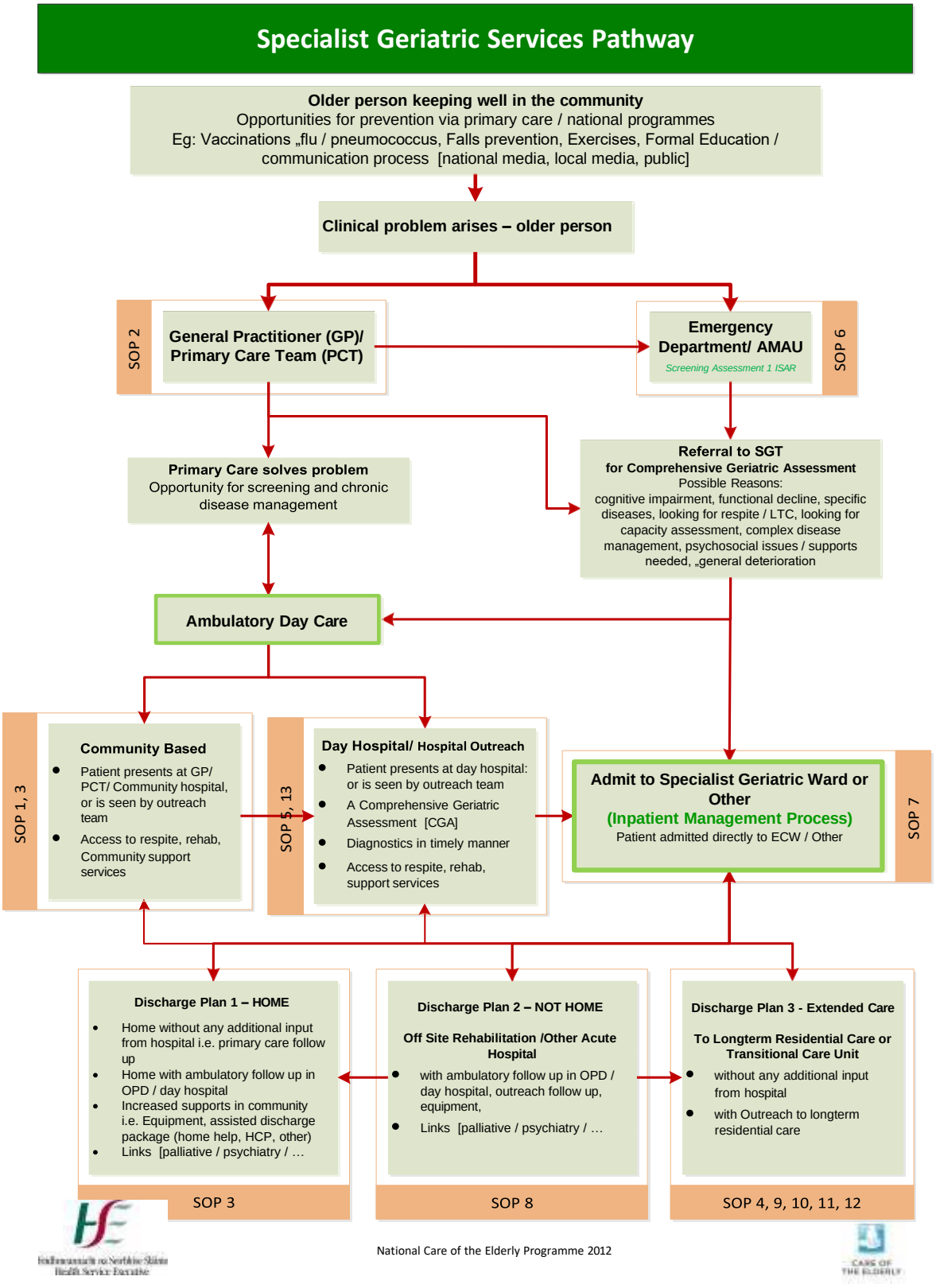
13 Appendix 3 - Key Performance Indicators

1.	**KPI title**	**CotE KPI 1: Patient throughput in Specialist Geriatric Wards**
2.	**Description**	**KPI 1.1** The number (N) of patients admitted to a specialist geriatric ward (SGW): total aged ≥ 65; number aged 65-79, aged ≥ 80 years **KPI 1.2** Percentage of patients admitted to an SGW directly from ED or within 2 days of hospital admission who have been discharged before day 19 in the SGW **KPI 1.3** Percentage of patients admitted to an SGW after 3 days or longer in other wards in the hospital who have been discharged before day 19 in the SGW
3.	**Rationale**	There is evidence that older patients needing complex care who are treated in an SGW have better outcomes compared to those treated on general wards. The aims of this KPI are: • To track progress in developing capacity in cohorted SGWs • To monitor access to specialist geriatric inpatient care • To monitor length of stay in SGWs (see also KPI 2)
4.	**Targets**	To provide for 25 000 admissions to SGWs of those aged ≥ 65 who require complex care For patients who are clinically fit, to discharge them or transfer them to another care location after 18 days in the SGW (see also KPI 2) Baseline capacity and throughput to be established by end Q2 2013, providing a basis for setting targets
5.	**KPI Collection Frequency**	❑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ☑Other – give details: Continuous collection via HIPE Portal
6.	**KPI Reporting Frequency**	❑Daily ❑Weekly ☑Monthly ☑Quarterly ❑Bi-annually ❑Annually Monthly analysis to support local monitoring of access and length of stay Quarterly collation to support national monitoring with sufficient numbers to permit meaningful review of throughput in hospitals and hospital networks in context of national data
7.	**KPI Calculation**	**KPI 1.1** The total N of patients aged ≥ 65 admitted to the SGW as recorded in HIPE Portal; N of patients aged 65-79; N of patients aged ≥80 **KPI 1.2** Numerator: patients admitted to an SGW before day 3 of their hospital admission and discharged by day 18 Denominator: all patients admitted to an SGW before day 3 of being admitted to hospital **KPI 1.3** Numerator: patients admitted to an SGW on day 3 or later in their hospital admission and discharged by day 18 Denominator: all patients admitted to an SGW on day 3 or later in their hospital admission
8.	**Reporting Aggregation**	☑ HSE National ☑HSE Region ❑LHO Area ☑Hospital ❑County ❑ Institution ❑CMHT ❑PCT ❑Age ❑Gender ☑ ❑Other – give details: Acute hospital; hospital network; region; national
9.	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE Portal for NCPOP to be developed. First module will include all patients admitted to an SGW. The aim is to collect data on all patients admitted to or transferred into an SGW. Training and clear definitions will be provided to support comparability of data entered by different professionals, on different sites and over time.
10.	**Tracer (Conditions) terms**	HIPE Portal will include all patients admitted to an SGW
11.	**Minimum Data Set**	Date admitted to hospital (HIPE) Date of birth (HIPE) Date admitted to the SGW (HIPE Portal) Date discharged from the SGW (HIPE Portal)
12.	**International Comparison**	No internationally accepted norm found and international comparisons would need to be adjusted for casemix See also KPI 2 re length of stay before and after clinically fit for discharge
13.	**Web link to data**	
14.	**Additional Information**	
15.	**Metric is a reporting requirement in which reports?**	❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ❑HealthStat ❑Other – give details:
Named contact for further information		Dr. Emer Shelley, Department of Public Health, c/o Dr. Steevens Hospital, Dublin 8. emer.shelley@hse.ie
Metric Sign off		

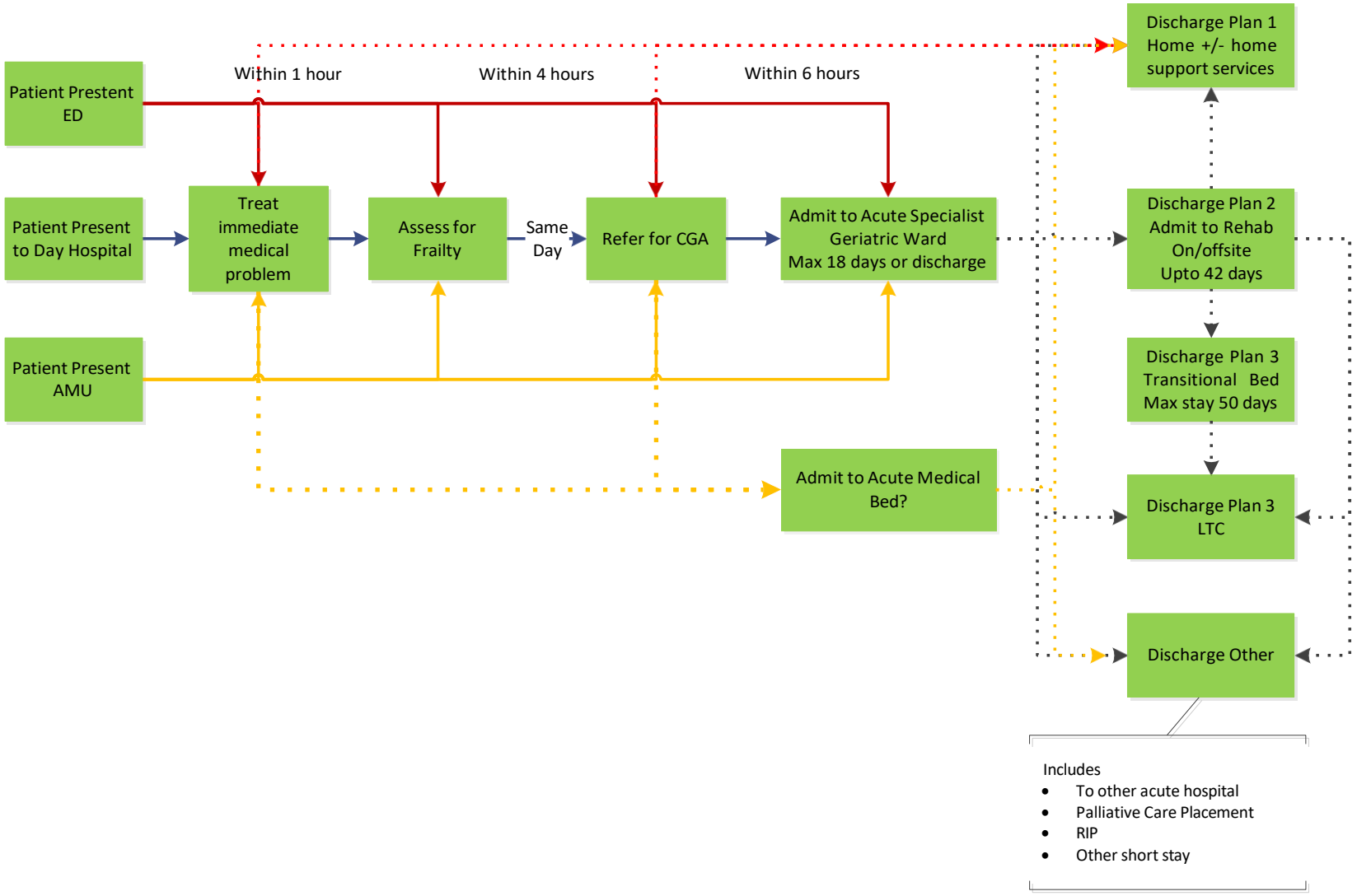
1.	**KPI title**	**CotE KPI 2: Length of stay in Specialist Geriatric Wards**
	Description	(1) For all patients admitted to a Specialist Geriatric Ward and discharged alive: median length of stay in SGW (a) before and (b) after clinically fit for discharge (2) For patients newly discharged to long term care: median length of hospital stay (a) before and (b) after CSAR submitted
3.	**Rationale**	Specialist Geriatric Services aim to reduce length of stay in beds designated for acute geriatric care. This is reflected in length of stay **before** patients are clinically fit for discharge and date by which CSAR is completed. Length of stay **after** these dates reflects effectiveness of discharge planning by SGS but is also dependent on access to services which are usually not managed by specialist geriatric services, vis. home care packages, offsite rehab, decisions re eligibility for financial support for long-term care and access to long-term bed.
4.	**Target**	• For patients admitted to an SGW and who are discharged alive, to discharge them or transfer them to another care location as soon as they are clinically fit • For patients admitted to an SGW and who are newly discharged to long term care, to reduce length of hospital stay (a) before and (b) after CSAR submitted • Baseline to be established by end Q2 2013, providing a basis for setting targets
5.	**KPI Collection Frequency**	√ ❑Daily Date each patient clinically fit for discharge and (where relevant) date CSAR submitted will be recorded in HIPE Portal for each patient admitted to an SGW ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
6.	**KPI Reporting Frequency**	❑Daily ❑Weekly √ ❑Monthly √ ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Monthly analysis to support local monitoring of access and length of stay Quarterly collation to support national monitoring with sufficient numbers to permit meaningful review of throughput in hospitals and hospital networks in context of national data
7.	**KPI Calculation**	**KPI 2.1 Median LOS <u>before</u> fit for discharge:** List bed days in SGW before clinically fit for discharge in ascending order of days for all patients admitted to an SGW and discharged alive If N of patients is an odd number, median = the middle one If N of patients is an even number, median = the average of the two values at the middle **Median LOS <u>after</u> fit for discharge:** List bed days in SGW after clinically fit for discharge in ascending order of days for all patients admitted to an SGW and discharged alive If N of patients is an odd number, median = the middle value of bed days If N of patients is an even number, median = the average of the two values at the middle **KPI 2.2 Median LOS <u>before</u> CSAR submitted:** List bed days in SGW before CSAR submitted in ascending order of days for patients admitted to an SGW and newly discharged to long term care If N of patients is an odd number, median = the middle one If N of patients is an even number, median = the average of the two values at the middle **Median LOS <u>after</u> CSAR submitted:** List bed days in SGW after CSAR submitted in ascending order of days for patients admitted to an SGW and newly discharged to long term care If N of patients is an odd number, median = the middle one If N of patients is an even number, median = the average of the two values at the middle
8.	**Reporting Aggregation**	☑ HSE National ☑ HSE Region ☑ LHO Area ☑Hospital ❑County ❑ Institution ❑CMHT ❑PCT ❑Age ❑Gender ❑Other – give details: Acute hospital; hospital network; region; national
9.	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE Portal for Care of the Elderly to be developed. First module of portal will include all patients admitted to an SGW. The aim is to collect data on all patients admitted to or transferred into an SGW. Training and clear definitions will be provided to support comparability of data entered by different professionals, on different sites and over time.
10.	**Tracer (Conditions) terms**	HIPE Portal will include all patients admitted to an SGW
11.	**Minimum Data Set**	Date admitted to hospital (HIPE) Discharge destination (HIPE and HIPE Portal) Date admitted to the SGW (HIPE Portal) Date clinically fit for discharge (HIPE Portal) Date CSAR submitted (HIPE Portal) Date discharged from the SGW (HIPE Portal)
12.	**International Comparison**	No internationally accepted norm found and international comparisons would need to be adjusted for casemix
13.	**Web link to data**	
14.	**Additional Information**	
15.	**Metric is a reporting requirement in which**	❑ Corporate Plan Report ☑ Performance Report (NSP/CBP)

1.	**KPI title**	**KPI 3: Outcomes after Hospital Care in Specialist Geriatric Ward**
2.	**Description**	KPI 3.1: Percentage of those admitted to or transferred into an SGW who are newly discharged to long term residential care KPI 3.2: Percentage of those admitted to or transferred into an SGW who are alive and at home (a) 6 months and (b) 12 months after discharge
3.	**Rationale**	Important aims of specialist geriatric services in acute hospital services are to improve functional outcomes and to reduce the percentage of patients discharged to long term residential care. These aims are consistent with evidence that patients receiving specialist care are more likely to be alive and at home 6 and 12 months after specialist inpatient care compared to similar patients cared for in general medical wards.
4.	**Target**	There is no system currently in place to follow patients after discharge from hospital so there is no information on outcomes after discharge. The number of patients going into long term residential care in recent years can be established but it's not always clear where the application originated and if they received inpatient care. Baseline to be established by end Q2 2013, providing a basis for setting targets
5.	**KPI Collection Frequency**	❑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ☑ Other – give details: Ongoing follow-up after discharge to establish if the patient is alive and living at home. Ongoing data capture in HIPE Portal to record location to which the patient is being discharged.
6.	**KPI Reporting Frequency**	❑Daily ❑Weekly ❑Monthly ☑ Quarterly ☑ Bi-annually ❑Annually ❑Other – give details: Quarterly analysis to support local monitoring of outcomes and discharge location, including new discharges to long term residential care Bi-annual collation to support national monitoring of outcomes and discharge location with sufficient numbers to permit meaningful review in hospitals and hospital networks in context of national data
7.	**KPI Calculation**	**KPI 3.1:** Percentage of those admitted to or transferred into an SGW who are alive and at home (a) 6 months and (b) 12 months after discharge Numerator – N of patients treated in an SGW who were admitted from location other than long term residential care and are alive and living at home (a) 6 months and (b) 12 months after discharge Denominator –N of patients treated in an SGW who were admitted from a location other than long term residential care **KPI 3.2** Percentage of those admitted to or transferred into an SGW who are newly discharged to long term residential care Numerator – N of patients treated in an SGW who were admitted from location other than long term residential care and are newly discharged to long term residential care Denominator –N of patients treated in an SGW who were admitted from a location other than long term residential care
8.	**Reporting Aggregation**	☑ HSE National ☑ HSE Region ☑ LHO Area ☑Hospital ❑County ❑ Institution ❑CMHT ❑PCT ❑Age ❑Gender ☑ Other – give details: Acute hospital; hospital network; region; national
9.	**Data Source** **Data Completeness** **Data Quality Issues**	When SGWs and specialist geriatric teams are established, systems (including consent) will be put in place to capture follow up data re patients' status and residence 6 and 12 months after discharge.
10.	**Tracer (Conditions) terms**	All patients discharged to location other than long term residential care will be followed up.
11.	**Minimum Data Set**	Patient name and address (patient's chart) Consent for follow-up (chart) Name and address of GP (chart) Date of discharge from SGW (HIPE portal) Discharge destination (HIPE and HIPE Portal)
12.	**International Comparison**	Any comparisons would need to be age-standardised and adjusted for complexity
13.	**Web link to data**	
14.	**Additional Information**	
15.	**Metric is a reporting requirement in which reports?**	❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ❑HealthStat ❑Other – give details:
Named contact for further information		Dr. Emer Shelley, Department of Public Health, c/o Dr. Steevens Hospital, Dublin 8. emer.shelley@hse.ie
Metric Sign off		

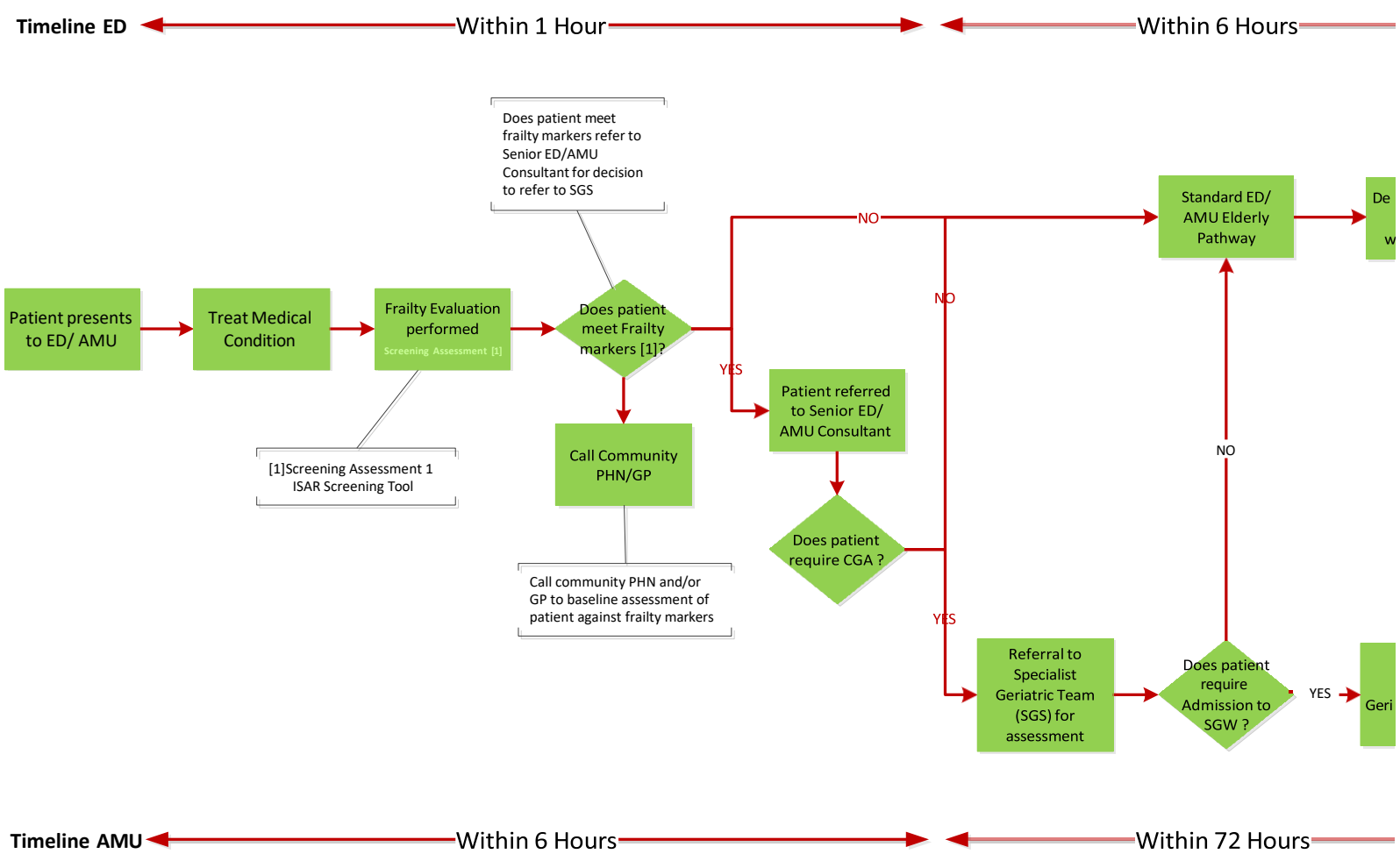
14 Appendix 4 – Care of the Older person Pathways and Process Flows

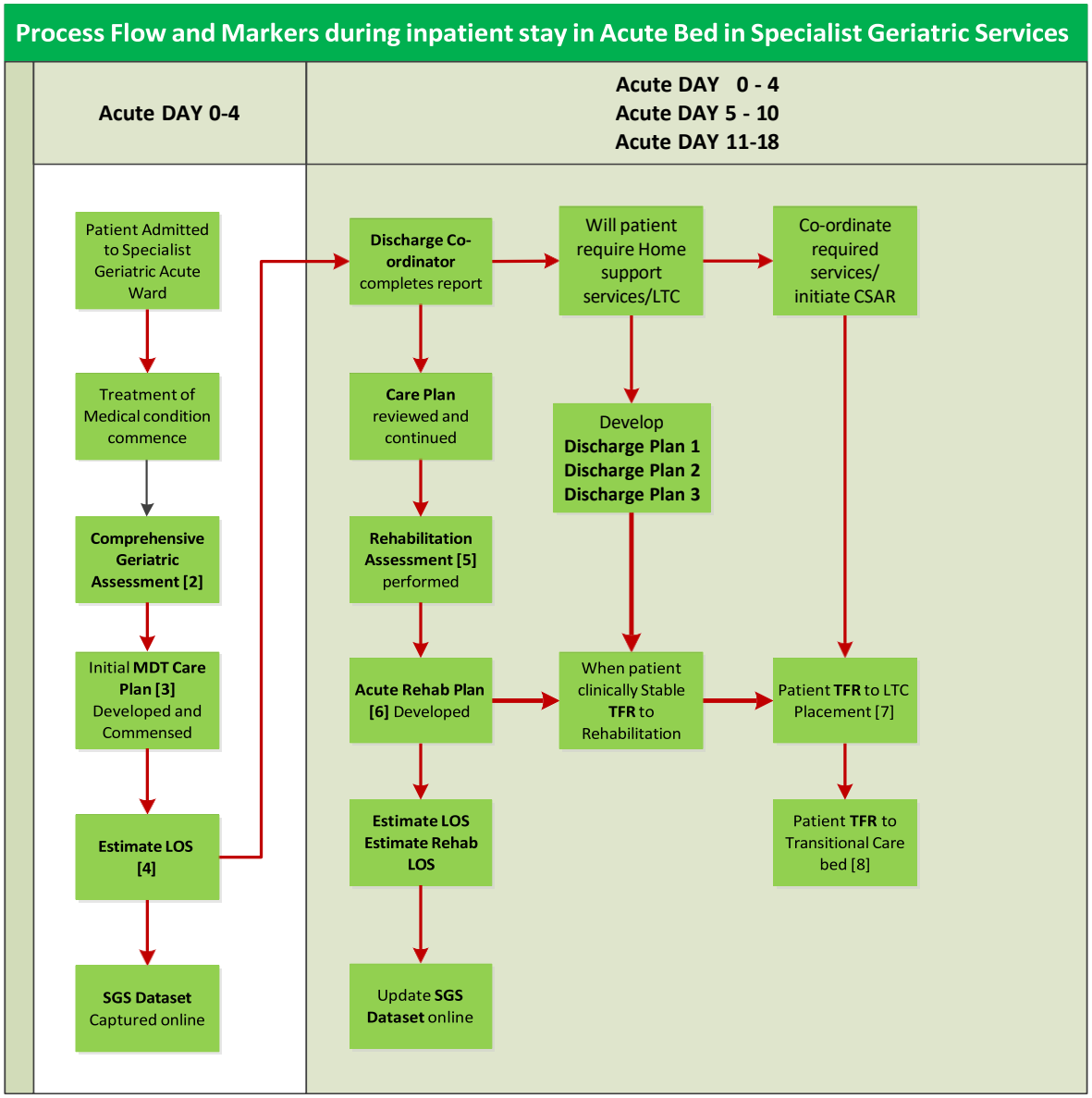


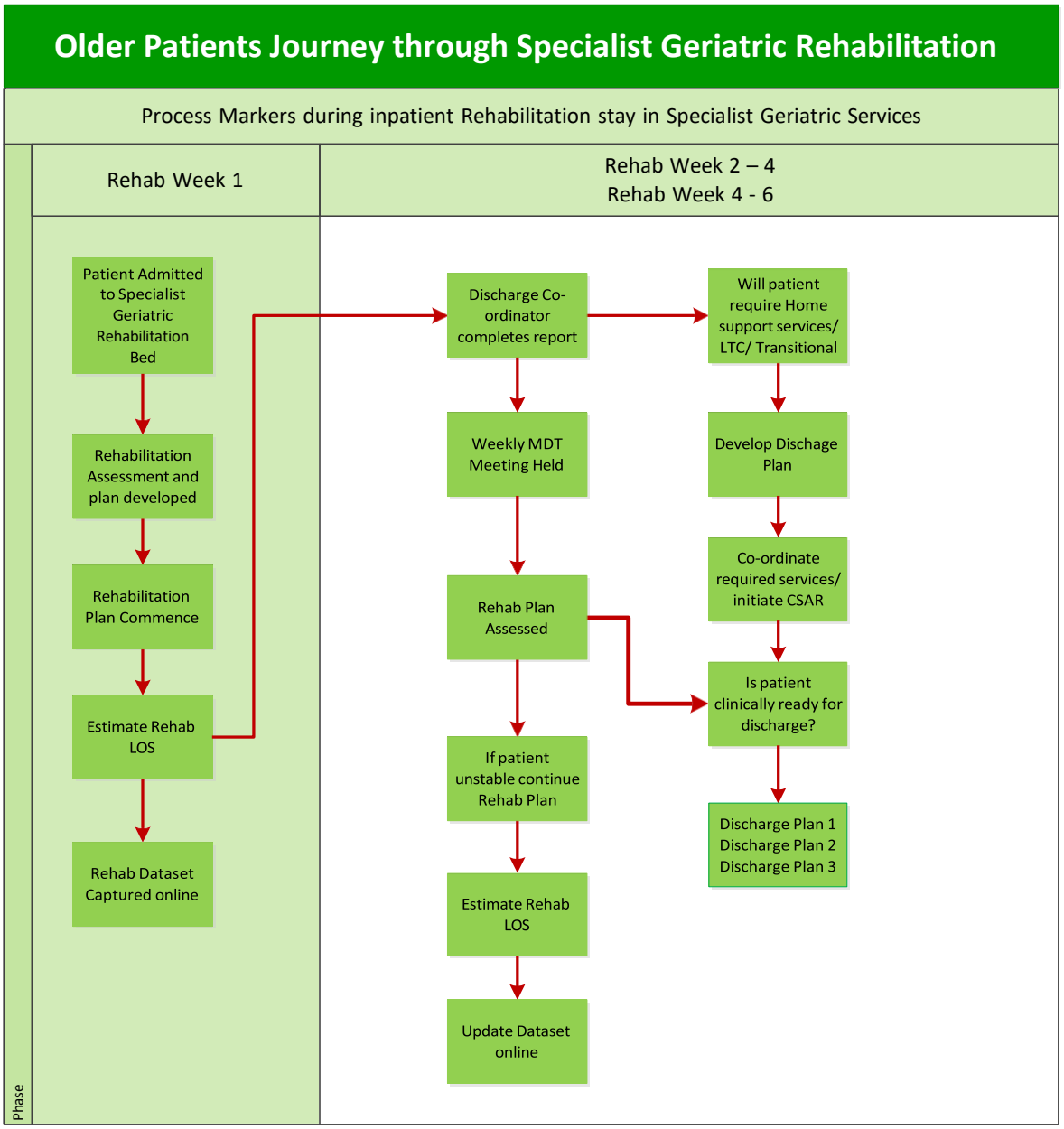
Overview of Acute Elderly Patient Journey



Older Patients Journey through ED/AMU




Process Flow and Markers during inpatient stay in Acute Bed in Specialist Geriatric Services
Acute DAY 0-4
Acute DAY 0 - 4
Acute DAY 5 - 10
Acute DAY 11-18
Patient Admitted to Specialist Geriatric Acute Ward
Treatment of Medical condition commence
Comprehensive Geriatric Assessment [2]
Initial MDT Care Plan [3] Developed and Commensed
Estimate LOS [4]
SGS Dataset Captured online
Discharge Co-ordinator completes report
Care Plan reviewed and continued
Rehabilitation Assessment [5] performed
Acute Rehab Plan [6] Developed
Estimate LOS Estimate Rehab LOS
Update SGS Dataset online
Will patient require Home support services/LTC
Develop Discharge Plan 1 Discharge Plan 2 Discharge Plan 3
When patient clinically Stable TFR to Rehabilitation
Co-ordinate required services/ initiate CSAR
Patient TFR to LTC Placement [7]
Patient TFR to Transitional Care bed [8]


Older Patients Journey through Specialist Geriatric Rehabilitation
Process Markers during inpatient Rehabilitation stay in Specialist Geriatric Services
Rehab Week 1
Rehab Week 2 – 4
Rehab Week 4 - 6
Phase
Patient Admitted to Specialist Geriatric Rehabilitation Bed
Rehabilitation Assessment and plan developed
Rehabilitation Plan Commence
Estimate Rehab LOS
Rehab Dataset Captured online
Discharge Co-ordinator completes report
Weekly MDT Meeting Held
Rehab Plan Assessed
If patient unstable continue Rehab Plan
Estimate Rehab LOS
Update Dataset online
Will patient require Home support services/ LTC/ Transitional
Develop Dischage Plan
Co-ordinate required services/ initiate CSAR
Is patient clinically ready for discharge?
Discharge Plan 1
Discharge Plan 2
Discharge Plan 3

Glossary of Notes in the pathway

[1] Patient assessed against markers of frailty scoring system and data recorded against bundle of care. Markers include:

- Falls
- Fractures
- Frequent ED AMU attendance
- 90 days post in patient discharge
- Dementia not Delirium
- Confusion
- Continence
- Living alone
- Dependency
- General condition

[2] Comprehensive Geriatric Assessment (CGA) performed within 48 hours of admission.

[3] All members of the Multi disciplinary team input into the care plan for the patient within 72 hours

[4] Length of stay to be estimated as output of CGA and reviewed at each checkpoint in the SGSP rocess

[5] A comprehensive assessment of the rehabilitation potential of the patient. The output of the assessment is the Rehab Plan .Assessment is Multidisciplinary and includes OT,SLT,Dietetics,Social Work and Pharmacy.

[6] Rehab Plan will cover the type and method for delivery of rehab along with the estimated duration and start date for rehab.

[7] Discharge patient to Long term nursing care and deemed the discharge destination and patient is clinically fit for discharge.

[8] When patient is clinically fit for discharge to Long term nursing care but cannot discharge due to wait for LTC placement; Patient eligible for transfer to transitional bed for agreed period of time. Inclusion/exclusion criteria for Transitional bed required

15 Appendix 5 – Single Assessment Tool

The interRAI assessment tool has been in development since the 1990s, is in use in over 30 countries, and has been extensively tested for reliability, validity and sensitivity. It is part of a suite of tools designed for use across a range of settings including long term residential care, disability and mental health services.

All interRAI™ assessment tools are composed of a minimum data set available in either paper form or electronically. They include a common core content of assessment variables and specialised data fields for use in different care settings and clinical areas (e.g. home care, nursing home, mental health). The core items have identical definitions, observation time-frames and scoring systems for use across care settings. Additional items specific to a particular care setting or unique to each individual person undergoing assessment may be added to the core data item set. This approach to instrument design yields the following benefits:

- Data can be transferred from one interRAI™ tool to another when individuals are accessing more than one service (e.g. home care and respite), or when they transfer between care settings (e.g. home care to nursing home; acute hospital to home care)
- Training of clinical staff who work in different settings is simplified
- A common language of assessment becomes available across the continuum of care.

The interRAI suite is currently composed of twelve related assessment systems, which include:

- interRAI™ HC (Home Care) – Full Assessment
- interRAI™ CHA (Community Health Assessment Screener)
- interRAI™ CA (Contact Assessment Screener)
- interRAI™ AC (Acute Care)
- interRAI™ PAC (Post-Acute Care)

Several quality indicators are included in the assessment tools. These draw attention to potentially good or bad practices and may be used by clinicians, managers, researchers and policy makers to examine changes in older persons with respect to service delivery. Examples of quality indicators which may be derived from using interRAI™ tools include:

- Prevalence of indwelling catheters, little or no activity, anti-anxiety/ hypnotic drug use
- Incidence of falls, new pressure ulcers, weight loss, worsening depression or anxiety

The work underway for the implementation of SAT in Ireland is

- to provide an accessible and easy to use information system to record comprehensive geriatric assessment and to generate decision-support outputs based on the assessment
- to test the feasibility of implementing the SAT in the community and acute care settings.

16 Appendix 6 - Standard Operating Procedures

The standard operating procedures as set out below are standalone documents as procedural guides to executing components of the Model of Care.

17 Appendix 7 – Clinical Governance

17.1 Introduction

Safety and high quality care requires vigilance and cooperation of the whole healthcare workforce. Improving quality and protecting patients from harm is our responsibility – clinical governance delivers the leadership and accountability systems to achieve this.

Clinical governance is described as a system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered. For health care staff this means: specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do.

Effective governance recognises the inter-dependencies between corporate, financial and clinical governance across the service and integrates them to deliver high quality, safe and reliable healthcare. Clinical governance means corporate responsibility for clinical performance built on the model of the CEO/GM or equivalent working in partnership with the clinical director, director of nursing/midwifery and the service/professional leads. This is based on the single point of accountability principle i.e. who ever is in charge of a health service, hospital or community, is responsible for the quality of care patients service and the patients health outcome.

17.2 Vision

It is anticipated that the further development implementation and ongoing commitment to quality and safety will create an environment where each individual as part of a team:

- knows the purpose and function of leadership and accountability for good clinical care;
- knows their responsibility, who they are accountable to and their level of authority;
- understands how the principles of clinical governance can be applied in their diverse practice; and
- consistently demonstrates a commitment to the principles of clinical governance in decision making

Resulting in:

- a culture of trust, openness, respect and caring which is evident among managers, clinicians staff and patients; and
- clinical governance being embedded within the overall corporate governance arrangement for the statutory and voluntary health and personal social services in realising improved outcome for patients.

17.3 Guiding Principles

To assist healthcare providers a suite of ten principles for good clinical governance, for the Irish health context, were developed with a title and descriptor. The principles developed by an interdisciplinary working group were reviewed for comprehensiveness, clarity and usefulness by health mangers, clinical directors, senior nurses and midwives, health and social care professionals and patient groups. It is proposed that the principles inform each action and provide the guide for mangers and clinicians in choosing between options.

Figure 2: Guiding principles

It is recommended that each decision (at every level) in relation to clinical governance development be tested against the principles set out in Figure 2 and described in Table 1.

Table 1: Guiding principles descriptor

Principle	Descriptor
Patient First	Based on a partnership of care between patients, families, carers an healthcare providers in achieving safe, easily accessible, timely and hig quality service across the continuum of care.
Safety	Identification and control of risks to achieve effective efficient and positiv outcomes for patients and staff.
Personal responsibility	Where individuals as members of healthcare teams, patients and member of the population take personal responsibility for their own and others healt needs. Where each employee has a current job-description setting out th purpose, responsibilities, accountabilities and standards required in thei role.
Defined authority	The scope given to staff at each level of the organisation to carry out thei responsibilities. The individual"s authority to act, the resources availabl and the boundaries of the role are confirmed by their direct line manger.
Clear accountability	A system whereby individuals, functions or committees agree accountabilit to a single individual.
Leadership	Motivating people towards a common goal and driving sustainable chang to ensure safe high quality delivery of clinical and social care.
Inter-disciplinary working	Work processes that respect and support the unique contribution of eac individual member of a team in the provision of clinical and social care Inter-disciplinary working focuses on the interdependence betwee

	individuals and groups in delivering services. This requires proactiv collaboration between all members.
Supporting performance	Managing performance in a supportive way, in a continuous process, takin account of clinical professionalism and autonomy in the organisationa setting. Supporting a director/manager in managing the service an employees thereby contributing to the capability and the capacity of th individual and organisation. Measurement of the patients experience bein central in performance measurement (as set out in the National Charter 2010).
Open culture	A culture of trust, openness, respect and caring where achievements ar recognised. Open discussion of adverse events are embedded in everyda practice and communicated openly to patients. Staff willingly report advers events and errors, so there can be a focus on learning, research an improvement, and appropriate action taken where there have been failing in the delivery of care.
Continuous quality improvement	A learning environment and system that seeks to improve the provision o services with an emphasis on maintaining quality in the future not jus controlling processes. Once specific expectations and the means t measure them have been established, implementation aims at preventin future failures and involves the setting of goals, education, and th measurement of results so that the improvement is ongoing.

17.4 Governance, leadership and accountability

Each healthcare provider has a responsibility to articulate the governance and accountability arrangements for quality and safety including the establishment of a quality and safety (clinical governance) committee with responsibility for overseeing clinical governance arrangements and reporting to the Board/ CEO/Executive Management Team. However committees cannot make clinical governance happen in practice without the proactive involvement of teams in the ward/department and in the community. While leadership, direction and support can come from management, it is clinical leadership and individual teams that deliver best care for patients and the public.

A Clinical leader *is a competent professional involved in providing direct and indirect clinical care who enables oneself and influences others to improve care.* Clinical Leadership *is about driving service improvement and the effective management of teams to provide excellence in patient care*.

The approach to clinical governance involves each individual working within their ward/department/ team having:

- Clear lines of responsibility authority and open accountability
- A commitment to implementing and maintaining standards
- A programme of improvement in systems and processes
- Objective, focused clinical audit
- Seeking feedback from patients, staff and members of the public
- Using data and evidence to drive change
- Participating in ongoing education and training
- Risk management and assurance processes
- Clarity on how they report into the quality and safety (clinical governance) committee

17.5 The multidisciplinary team‟s role in quality and safety

The focus is on creating the atmosphere and culture where excellence can flourish with strong multidisciplinary team collaboration.

Multidisciplinary teams *consist of representatives from different disciplines and professional backgrounds who each have complementary experience, qualifications, skills and expertise. Members of the team provide different services for patients in a coordinated and collaborative way. Membership of the team may vary and will depend on the patient's needs and the condition or disease being treated.*

A culture and commitment to agreed service level and the quality of care to be provided are characteristic of clinical governance. The quality of care a patient receives depends on the care of a whole chain of actions and individual professionals are just one link in that chain. If clinical governance is to be effective, it must start with the patient and build through the organisation from there. Clinical governance is a truly multidisciplinary activity.