

# National Clinical Programme for Older People

## Launch of a Model of Care for Specialist Geriatric Services



**Every older patient has access to the right care, in the right place,  
at the right time**

## Introduction

The majority of older people are well, living independently in the community. However, with improved life expectancy, an increasing number of people suffer from multiple chronic illnesses, frailty, poly-pharmacy and other syndromes associated with ageing. High quality health and social services for older people provide continuity of care, integrated between care settings. There are a number of key constituents to comprehensive services 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.

Most health care for older people is provided in the community, though acute deterioration in health may result in referral to an acute hospital. Attending hospital, particularly if referred as an emergency, can be a time of disruption and concern for the older person and their family. Age-attuning the acute medical system is the initial focus of the Model of Care for Specialist Geriatric Services. Not all older patients can, will or need to be looked after by geriatricians, but all patients should expect that those who provide their care have training and competence in geriatric medicine as a core element of their training. The challenge for the specialty of geriatric medicine is to maintain their areas of expertise whilst contributing to the development of the acute medical services.

Older people with complex illnesses and deteriorating health benefit from specialist geriatric services, provided in a dedicated ward by a multidisciplinary team. In addition to improving patient outcomes and increasing service efficiency, specialist services can contribute to training and advise on the care of older people by other services in the hospital and community settings.

## The Model of Care for Specialist Geriatric Services

The Model of Care for Specialist Geriatric Services, Acute Service Provision, is Part 1 of a two part model of care. Part 1 describes the patient's journey within the acute hospital as an inpatient or outpatient in specialist clinics or ambulatory day hospital. Part 2 of the model of care will address services for older people in general practice, primary and community care and is due for completion in 2013.

The components of acute Specialist Geriatric Services (SGS) include:

- The establishment of specialist geriatric teams
- Dedicated in-patient specialist geriatric wards
- In-patient rehabilitation facilities (both on and off the acute hospital site)
- Community outreach to nursing homes
- Ambulatory day hospital services
- Access to home supports
- Access to long term residential care

## Recommendations of the Model of Care for SGS

- Each SGS has defined and agreed criteria with their ED, AMU and Community to determine whether a patient should be referred to the SGT.
- Each ED / AMU in conjunction with the SGS has in place an agreed process for identifying the frail / at risk older patient.
- The SGS links with the ED / AMU when an older person at risk is identified as requiring referral , including for comprehensive geriatric assessment (CGA) or admission to a specialist geriatric ward.
- Once referred, decisions about the appropriate SGS to meet the patient's needs are made by a senior professional to a specified timeframe.
- All identified older frail patients have a timely CGA performed and documented in their permanent health record, accessible to both the primary and secondary care teams.
- Each hospital receiving acutely ill older adults has a dedicated Specialist Geriatric Ward with appropriate staffing levels and a designated multidisciplinary specialist geriatric team.
- Each hospital has access to onsite and off-site rehabilitation beds and delivers a structured rehabilitation programme for older people.
- A systematic approach to discharge planning is facilitated by admission of the frail older person into an SGW with an SGT. Each hospital has an SGT, with clear responsibility and processes for CGA, integrated discharge planning, and communication with the patient and professionals in other care settings.
- Each SGS provides outpatient services, including subspecialty clinics, with rapid access slots for urgent referrals.
- Each hospital receiving acutely ill older adults has an onsite day hospital capable of meeting the needs of the catchment area population.
- Each SGS provides an outreach service, prioritising patients in long term care referred by the GP or Medical Officer. The outreach service liaises with psychiatry for older persons, and supports training and education of community based staff.
- Each hospital-based SGT has agreed protocols to facilitate communication with GPs and PCTs. A single access point is established to support referral. Outcome of hospital assessment and care is communicated in a timely manner to the referral source.

## The Benefits of Implementing the Model of Care for SGS

The benefits of implementing the model of care for SGS outweigh the costs of establishing the specialist service. Improved outcomes for patients and their families will become apparent soon after the model is embedded from 2013 onwards. The key benefits include:

- Better access to CGA
- Enhanced access to specialist inpatient geriatric ward and rehabilitation services
- Better patient outcomes including:
  - Reduced deaths
  - Reduced dependency
  - More patients discharged home
- Overall reduction in acute inpatient bed days through the following;
  - Early identification of 'frail older people' in the ED and AMU
  - Reduction in inpatient average length of stay
  - Reduction in delayed discharges

## Implementation of the Model of Care

The Model of Care for SGS sets out a framework for services for frail older people presenting to the acute hospital. Whilst some hospitals will start to implement the model in its entirety, other hospitals will concentrate in the first instance on some aspect of the model where they have an important gap in service. National implementation of the model will be on a phased basis. Phase 1 has commenced targeting the greater Dublin area, Louth/Meath and Kildare hospitals, with Phase 2 coming on stream in Q4 2013.

## More Information

For more information and for a copy of the Model of Care for Specialist Geriatric Services, please visit [www.hse.ie/eng/about/Who/clinical/natclinprog/OlderPeople](http://www.hse.ie/eng/about/Who/clinical/natclinprog/OlderPeople) Clinical Programmes page for Older People or contact NCPOP programme manager at [clinicalprogrammeadmin@rcpi.ie](mailto:clinicalprogrammeadmin@rcpi.ie).



**OLDER  
PEOPLE**