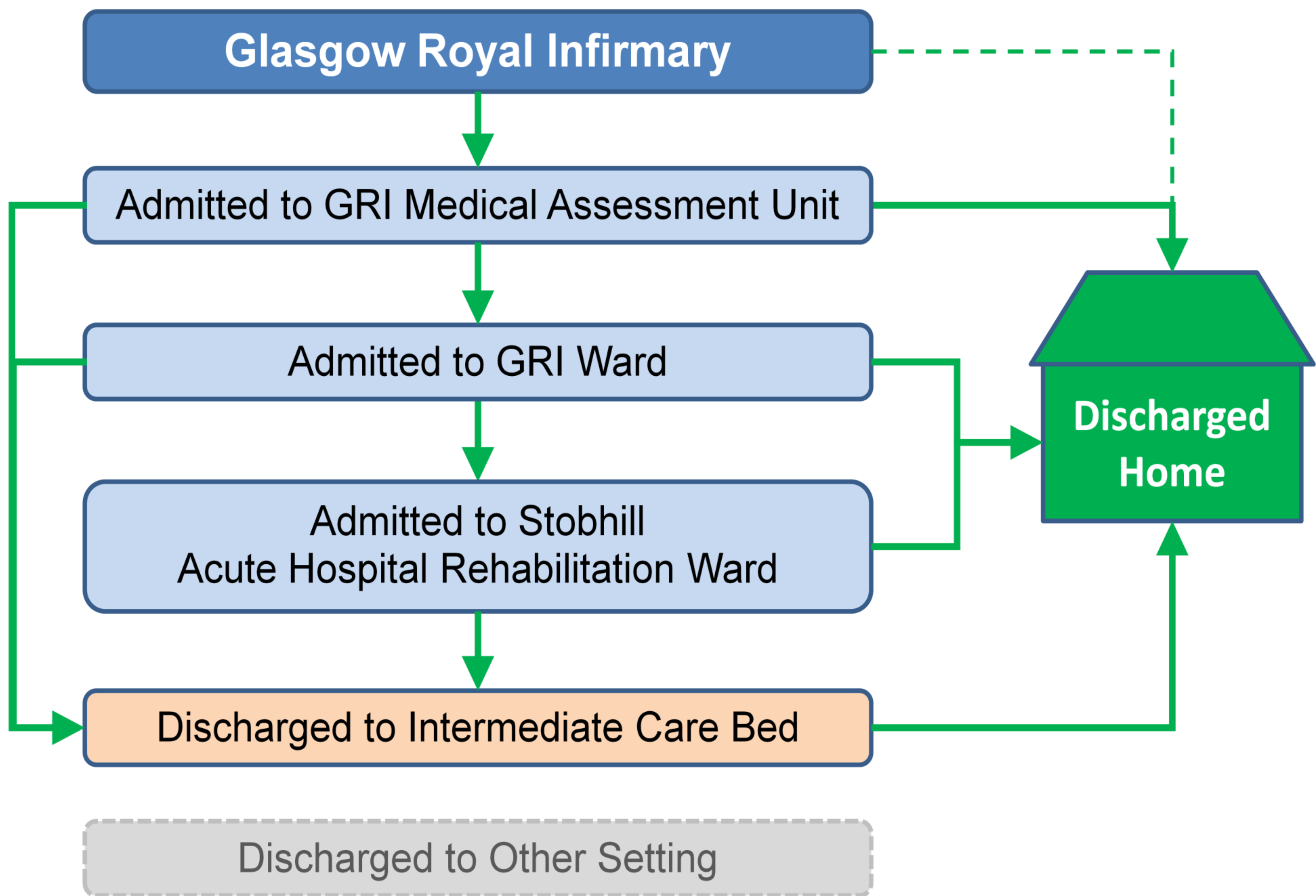
Elderly Rehabilitation in North East Glasgow: Proposed New Pathway



1. **Glasgow Royal Infirmary:** All elderly people from across the whole of North East Glasgow and East Dunbartonshire attend the **Emergency Receiving Complex** at the Glasgow Royal Infirmary (GRI). The **Emergency Receiving Complex** consists of the **Accident and Emergency Department** and the **Acute Assessment Unit** where patients receive their initial diagnosis and assessment. This can include the **Target Team** initiating a **Comprehensive Geriatric Assessment**. From here patients can sometimes return home but if they need further investigation or assessment they are admitted to the **Medical Admissions Unit**.

2. **Medical Admissions Unit:** If the Injury or illness requires treatment or further assessment the patient is usually first admitted to the **Medical Admissions Unit**. This includes a specific area called the **Acute Frailty Unit** where **Geriatricians, the Target Team and** other **Allied Health Professionals** will determine whether they can go home, require to be admitted to another ward, or intermediate care **Step Up Bed**

3. **Discharged Home:** Following initial investigation and assessment the majority of elderly patients are discharged home. This might be with a **Package of Care** or with input from the **Community Rehabilitation Team.** Also patients can attend the **Day Hospital** as an outpatient.

4. **Admitted to GRI Ward:** If the Injury or illness requires treatment patients are admitted to a **General Medicine** or **Geriatric Medicine Ward**. From here people can be discharged home, admitted to Stobhill for further **Acute Hospital Rehabilitation**, or discharged to **Intermediate Care**.

5. **Admitted to Stobhill Acute Hospital Rehabilitation Ward:** If a patient requires **Acute Hospital Rehabilitation** they will be admitted as an inpatient. Here the patient can undergo **Rehabilitation** on a site with a full a range of **Support Services and Specialities**. From here patients can go home or they might need a period of **Reablement** and discharged to a **Community Bed** within **Intermediate Care.**

6. **Discharged to Intermediate Care Bed:** If a patient requires further **Rehabilitation**, but does not need the full backup of an **Acute Hospital** they can access **Step Down Beds** in local **Care Facilities**. Here they can undergo **Reablement** in a more homely setting. People can also be admitted to prevent admission to an **Acute Hospital**.

7. **Discharged to Other Setting:** The Goal of **Rehabilitation** is to keep people living at home independently. However, the illness or injury in some cases will mean that the individual might need to be discharged to a **Care Home** on a more permanent basis, or require the support of specialist care within **Palliative Complex Care** or **Adults With Incapacity**.

Glossary of terms:	
Acute Frailty Unit:	A ward for frail elderly patients where specialists in elderly care carry out assessments and investigations.
Acute Hospital:	Acute care is the early and specialist management of patients suffering from a wide range of medical conditions requiring urgent or emergency care usually within 48 hours of admission or referral from other specialties. Acute hospitals are those intended for short term medical and/or surgical treatment and care.
Acute Hospital Rehabilitation:	Where a patient has had treatment for their injury or acute illness, but still requires a period of rehabilitation in an acute hospital with access to the range of specialist hospital services they provide such as tests, scans or other investigations as part of their ongoing recovery
Adults With Incapacity :	Patients that do not require acute hospital care, but lack the capacity to live independently because they cannot make some or all decisions for themselves.
Allied Health Professionals:	Allied health professions are health care professions distinct from nursing, medicine, and pharmacy. They work in health care teams to make the health care system function by providing a range of diagnostic, technical, therapeutic and direct patient care and support services that are critical to the other health professionals they work with and the patients they serve.
Care Facilities:	These are specific single ensuite room bed areas within local care homes commissioned by the Health and Social Care Partnership to provide rehabilitation in a more homely, residential setting.
Care Home:	A care home or intermediate care facility provides a type of residential care. It is a place of residence for people who require care but are no longer in need of acute care.
Community Bed:	A bed in a single ensuite room provided in a local care facility for patients who are not yet able to return home but no longer need to support of an acute hospital.
Community Rehabilitation Team:	The team of Allied Health Professionals who provide rehabilitation directly within people's homes and in local Care Facilities either following a hospital admission or to prevent this from happening.
Comprehensive Geriatric Assessment:	Comprehensive geriatric assessment is a multi disciplinary diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances. The purpose is to develop a plan for treatment, rehabilitation, support and long term follow up.
Day Hospital:	A day hospital is a facility that offers a range of focussed health care, such as rehabilitation services, to individuals who require those services but are able to return to their homes overnight.
Emergency Receiving Complex:	The area of an acute hospital where emergency patients receive their initial assessment and diagnosis.
General Medicine Ward:	A ward in the hospital where patients are cared for if they have been diagnosed with a medical specialty condition such as respiratory, rheumatology, gastroenterology, cardiology or endocrinology.
Geriatricians:	Geriatrics or geriatric medicine is a specialty that focuses on health care of elderly people. It aims to promote health by preventing and treating diseases and disabilities in older adults. A geriatrician or geriatric physician, is a physician who specialises in the care of elderly people
Geriatric Medicine Ward:	Is a ward that focuses on the health and care of elderly people
Intermediate Care:	Intermediate care is for patients who need a short term step between hospital and home after they've had hospital treatment or to prevent them needing a stay in hospital. It provides short term support for people who are well enough not to need an acute hospital but need extra support before they can return home Intermediate care settings are places that patients stay for a short time while they undergo assessment, rehabilitation and/or reablement. The care is split into 'step up' or 'step down' care. Going through intermediate care usually involves moving into a specially set aside short term bed in a care home so that the team who work in the intermediate unit can assess what care is required. These units are designed to feel more like being at home rather than being in hospital.
Medical Assessment Unit:	An area of the hospital where patients needs are further assessed to determine where their treatment should best be delivered.
Package of Care:	A community based service or community provided equipment or number of coordinated services that support a patients return to their own home.
Palliative Care:	Palliative care is the active care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is the achievement of the best quality of life for patients and their families.
Reablement:	Providing personal care, help with daily living activities and other practical tasks, reablement encourages service users to develop the confidence and skills to carry

	out these activities themselves and continue to live at home.
Rehabilitation:	Rehabilitation caters for the needs of older people who have suffered an injury or are recovering from an illness. The goal of rehabilitation is to help people get back to their previous level of function and wellbeing. This includes personal care and mobility.
Step Up Bed	A community based bed which provides the level of care needed without the requirement for an acute hospital admission
Step Down Bed	A community based bed which provides the level of care needed to allow a patient to leave an acute hospital
Support Services and Specialties:	The range of specialist services only available on acute hospital sites which include: Laboratory medicine and phlebotomy – for testing blood and other samples Imaging and Diagnostic services – such as X-ray ultrasound MR and CT Orthotics – for the supply of special aids to mobility and stability Pharmacy- for the provision of onsite medicines Cardiology – for examining the heart And Liaison from a range of other specialties so that complex decisions can be taken on a team basis
Target Team:	Senior AHP, Consultant and Elderly Care Assessment Nurse who can identify patients likely to be able to be discharged rapidly from GRI if provided with enhanced Allied Health Professional input. These patients will be supported by the Target Team who will link with established community teams to facilitate discharge back into the community as early as possible.