

Appendix H

St. Joseph's Continuing Care Centre Geriatric Rehabilitation Unit

Service Definition:

A CCC based program that provides medical and functional rehabilitation for frail older persons (generally 65 and over) experiencing failure to thrive and who cannot tolerate the intensity and frequency of a regular rehabilitation program. These patients require inpatient management of geriatric conditions that threaten their ability to return to the community (e.g. falls, delirium, depression, incontinence, malnutrition, polypharmacy, pain).

Service Description:

Length of Stay	Less than 30 days
Rehabilitation Schedule	Participation in scheduled rehabilitation activities a minimum of 90 minutes daily, which includes Physiotherapy, Occupational therapy, Recreation Therapy, and Nursing Restorative activities. Patients are also expected to participate in their daily care.
Population Served	Individuals 65 years of age and older (individuals less than 65 years old may be considered for admission based on need and comorbidities)

Interprofessional Team Geriatrician, Physicians, Nurses, Pharmacist, Occupational Therapists, Physiotherapist, Recreation Therapists, Dietitian, Speech Language Pathologist, Spiritual Health Practitioner, Social Worker, Rehabilitation Assistants

Services Provided:

- Oxygen therapy
- Tracheostomy care
- Deep suctioning
- Continuous Positive Airway Pressure (CPAP)
- Peritoneal dialysis
- Hemodialysis
- Continuous bladder irrigation
- Complex wound care
- Intravenous medication and fluid administration
- PICC lines, port-a-caths, Hickman catheters, AV dialysis catheters
- Pain and symptom management
- Collection and analysis of blood specimens during and outside of regular business hours

Inclusion Criteria:

- Medically stable as demonstrated by the following:
 - Clinical course of the patient is largely predictable,
 - A clear diagnosis and co-morbidities have been established, treated, and managed,
 - At the time of discharge from acute care, acute medical issues have been addressed,
 - Disease processes and/or impairments are not precluding participation in the program,
 - Patient's vital signs are stable or as expected,
 - No undetermined medical issues (e.g. not yet diagnosed) exist that preclude care in post-acute settings (e.g. excessive shortness of breath, falls, CHF),
 - C-PAP, BiPAP settings are stable and manageable in the community/post-acute setting,

- Medication needs have been determined , are deemed effective and are manageable in the community/post-acute setting,
- Oxygen weaning and trach discontinuation is complete or manageable in the community/post-acute setting.
- Demonstrates potential to improve functional status to level required for discharge
- Able and willing to participate in individualized rehabilitation programming and to actively participate in activities of daily living (see Therapy Schedule under Service Description section)
- Documented commitment to returning to community.

Exclusion Criteria:

Applicants with one or more of the following potential exclusion criteria will be considered on an individual basis to determine his/her appropriateness for the program:

- Unstable medical, psychiatric, or addictions condition requiring acute intervention or constant nursing care,
- Delirium of unknown origin
- Require 1:1 supervision related to responsive behaviours
- Wandering or exit-seeking behaviour requiring a secure unit
- Severe behavioural problems that pose a threat to themselves or others
- Demonstrated non-compliance and/or expressed unwillingness or refusal to actively participate in therapy.
- Significant attention, judgment, alertness or orientation deficits that would interfere with participation/safety in the program or the safety of others on the unit
- Cognitive impairment preventing adequate assessments and interventions, and/or where information presented cannot be learned, retained, or carried over
- Isolation precautions requiring negative pressure room

Discharge Criteria:

- Identified rehabilitation goals have been attained, potential for improvement has been maximized, or patient's gains have plateaued, and any further therapy can be continued in the community,
- Medical condition is stable and current medical needs can be met in an alternate setting (e.g. community, long-term care),
- Patient and/or caregiver has been noncompliant with rehabilitation program
- Patient is able to be supported in the community to perform ADL's.
- The patient's condition becomes unstable and transfer to another facility is necessary to meet his/her medical or psychiatric needs.

NOTE: Assessment and counseling for LTCH placement can take place in the Geriatric Rehabilitation Unit, however, the patient will return home to wait for a LTCH bed.

NOTE: If the patient is on a waitlist for LTC and is offered a LTC bed while awaiting admission to the GRU, he/she should be admitted to LTC first and then arrangements can be made for an admission to GRU. LTC patients must return to their LTC bed within 30 days of admission to the GRU.