

# GERIATRIC DAY HOSPITAL



# MISSION

- To provide interdisciplinary assessment, consultation and rehabilitation services to community dwelling older adults and their families.
- To optimize their health and functional status and to assist them to maintain their independence in an appropriate environment.

- Community based program at five sites:
  - Deer Lodge Centre
  - Riverview Health Centre
  - 7 Oaks Hospital
  - St. Boniface Hospital
  - Health Services on Elgin (which offers many programs and services similar to the day hospitals)

# WHO IS THE TEAM



- Each day hospital has a health care team which sets up individualized treatment programs for the clients
- Health care providers include:
  - Nurse case manager
  - Physiotherapist
  - Occupational therapist
  - Social worker
  - Health care aide and rehab assistant
  - Secretary/unit assistant

- The health care team may also include
  - Recreation therapist
  - Dietitian
  - Chaplain
  - Speech language pathologist
  - Pharmacist
  - Geriatrician
  - Geriatric psychiatrist

- Teaching centre for medical residents, nursing students and allied health professionals.
- Which discipline works with a client is dependent on individual needs
- Day hospital does not replace the client's family physician, but they do work closely with family physicians, home care and community agencies.



# ELIGIBILITY FOR DAY HOSPITAL



- Frail older adults over 65 with complex medical and psychosocial needs
- Would benefit from day hospital to help reach and maintain a healthy level of physical, mental, emotional and functional health
- Client is willing to participate in the program and to attend regularly

- Family physician is aware and in agreement with the referral
- Client's address determines the day hospital they attend (exceptions include rural Manitobans and Francophone population)

# WHO CAN REFER TO DAY HOSPITAL

- Referrals come from a variety of health care resources
  - Family physicians/Primary care providers
  - Home care case coordinators
  - Geriatric Program Assessment Team
  - Geriatric Mental Health Team
  - Acute care hospitals, including emergency
  - Inpatient geriatric rehab units

# REASONS FOR REFERRAL

- Falls
- Unexplained decline in function
- Social isolation
- Memory loss
- Behavioural changes
- Depression
- Caregiver stress
- Long term planning



# PROGRAM

- Assessment of health and care needs
- Treatment and rehabilitation as required
- Transition from hospital to community
- Health promotion and support
- Discharge planning and community follow up
- Geriatrician/geriatric psychiatry consultation

# CORE PROGRAMS

- COMPREHENSIVE GERIATRIC ASSESSMENT
- In-depth assessment of client's function including activities of daily living, physical well-being and memory
- Often includes a home visit
- Process to identify health needs as client attends the day hospital program



- COMMUNITY TRANSITION
- Focused on clients discharged from hospital geriatric inpatient units returning to community living
- Goal is to provide smooth continuation for rehabilitation for those requiring general monitoring, mobility and group exercises

- FALL PREVENTION
- Assessment and treatment for individuals at high risk for falls
- Attend twice weekly for eight weeks
- Includes group exercises and education as well as individualized treatments

- NON-SPECIFIC GERIATRIC REHABILITATION
- Extended assessment, general strengthening and conditioning
- Participation in recreational program, group exercises

# GERIATRICIAN/GERIATRIC PSYCHIATRY

- Geriatrician and geriatric psychiatrist offer comprehensive assessment for appropriate clients
- Reasons may include declining function, pain, medication review
- Memory assessments
- Psychosocial support – management of mood, anxiety and behavioural behavioural
- Followed over time or seen only once
- Family physicians are always informed of assessments and recommendations



# WHAT HAPPENS AT DAY HOSPITAL

- Initial assessments with health team members
- Weekly follow up/treatment with health team
- Group exercises, including balance classes, weight bearing classes and chair exercises
- Walking programs
- Recreational and social programs
- Usually attend weekly – lunch is included in the program
- There is no charge, except if the clients use the private van service

- Clients may only need to attend day hospital once or twice, but most attend weekly for 6 to 12 weeks
- During their attendance, they receive regular support and follow up with the nurse case managers
- Interdisciplinary case reviews are done during the program
- When clients are nearing completion of the program, discharge planning is done. This may include family conferences, medication reviews and referrals to appropriate community resources such as home care, Adult Day Programs and PRIME.

