The GARU: Innovative Interdisciplinary Care for the Complex Geriatric Population
Halton Healthcare

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Introduction

Halton Healthcare has been a member of NICHE since 2009, achieving and maintaining exemplar status since 2013. The Geriatric Assessment Rehabilitative Unit (GARU) is situated at the Oakville site, which newly opened in 2015, serving the community with 430 beds.

Purpose

On April 1, 2016 Halton Healthcare embarked on a journey to improve interdisciplinary Geriatric care on the Acute Inpatient Rehabilitation unit (4N). The GARU is a 10 bed inpatient cluster providing specialized, comprehensive inter-professional assessments of geriatric patients to optimize their medical and functional status through rehabilitation. A multidisciplinary post-acute geriatric unit is associated with a reduction in functional decline and long-term mortality compared to usual care (St. John, 2016).

Methods

Referrals are accepted from Acute Inpatient Units, Emergency Department via Geriatric Emergency Management nurse and Family Physicians in the community (in consultation with the Geriatrician). Patients receive daily therapy streamlined to their specific needs by a multidisciplinary team (PT, OT, SLP, pharmacy, nursing, social work, and recreation). Daily medical care is provided by the most responsible physician.The team meets weekly with the Geriatrician to discuss the patient's progress and readiness for discharge. Expected length of stay (LOS) is 2-6 weeks.

Results: April 1, 2016 to Sept 30, 2016

Number of patients admitted and discharged: **32**
LOS: **average** 30.5 days (4.36 weeks), 66% **within** target range, 15% **under** target, 19% **over** target, 81% total **at or below** target LOS
Most common reason for admission: fall(s) **~50%**
Patients discharged home: **97%** (n=31)
Re-admission rates @ **30 days: 6%** (n=2) corporate average for seniors: **13.29%**
Re-admission rates @ **90 days: 9%** (n=3)

Discussion

Patients admitted to the GARU were highly medically complex and frail. Discharge planning was problematic in some situations, affecting expected LOS. Polypharmacy and intensive case review by Geriatric service was labour-intensive and time-consuming. Other challenges include the development of unrealistic expectations of family once the patient is in a rehab environment. Further measures to be tracked are readmission rates and patient/family satisfaction. Two patients were successfully admitted from the community as directed by the outpatient geriatrician, avoiding ED visit and bypassing acute medical unit. Consider investment in outpatient Falls Prevention Programs in the community.