Queensland Health

Geriatric services

CSCF v3.2

Module overview

Please note: This module must be read in conjunction with the Fundamentals of the Framework (including glossary and acronym list).

Geriatric services are a specialist area of medicine concerned with the health care, social aspects, preventative and rehabilitation needs of older persons both in health and illness. It involves the maintenance of health and the treatment of disease in older people, and therefore has a broad role across the full health service continuum for older people from home to hospital to home again (modified from Royal College of Physicians, 2000).[1]

Geriatric services include assessment, treatment, rehabilitation and clinical advice and liaison for older people with physical, cognitive impairment / dementia, mental health and/or functional support needs. Fundamental to effective geriatric service is **comprehensive geriatric assessment**, defined in this module as:

- a comprehensive assessment of an older person covering at a minimum current active medical problems; past medical history; medication review; immunisation status; advance care planning arrangements; current and previous physical function including personal, domestic and community activities of daily living; psychological function including cognition and mood; and social function including living arrangements, financial arrangements, community services, social support and carer issues.[2]

Services are typically provided by multidisciplinary teams of health professionals with specific qualifications and/or expertise in disease processes and injury in older people, and in assessment and rehabilitation for older people. Some geriatric services may include an ongoing maintenance component to the management of the aging patient. Health care facilities are not obligated to provide designated specialist geriatric services however where they do, these services are required to be consistent with the minimum criteria relevant to the specified service capability levels outlined in this module.

Queensland Health and the Australian Government use identified age ranges to describe the target group of older people i.e. people aged 65 years and older. While these ranges are supported for use in data collection and service planning, in clinical practice, age is not the focus, rather frailty, co-morbidities and degenerative, disabling and age-associated conditions (functional, cognitive and physiological profiles) are the relevant indicators for geriatric services. It is recognised problems for older people are multifactorial, and functional impairment can be due to multiple medical and psychosocial issues.[3]

Health services also experience ongoing challenges to ensure they are responsive to the needs of Aboriginal and Torres Strait Islander peoples. The provision of services to older Aboriginal and Torres Strait Islander people requires an understanding and respect for cultural differences and needs. Consistent with current Australian Government guidelines, older age for Aboriginal and Torres Strait Islander peoples starts at 50 years. Although individual Aboriginal and Torres Strait Islander people may not themselves feel old at 50, the reduced average lifespan and compounding effects of co-morbidities in this population often means the effects of ageing can manifest in people as young as 45 years.

For the purposes of this module, a specialist geriatric services focus transcending the continuum of services for older patients, relative to acute and sub-acute health services, has been adopted to inform module development. The geriatric services falling within the scope of this module and the broader CSCF are outlined in Table 1.

Table 1: Geriatric services and their location within the CSCF

Geriatric services	CSCF module
Emergency Geriatric Care services	Geriatric services module
Geriatric Acute Inpatient services	Geriatric services module
Geriatric Ambulatory services	Geriatric services module
Geriatric Cognitive Impairment services	Geriatric services module
Geriatric Consultation Liaison services	Geriatric services module
Geriatric Evaluation and Management services	Geriatric services module
Geriatric Interim Care services	Geriatric services module
Geriatric Rehabilitation services	Geriatric services module
Ortho-geriatric services	Geriatric services module
Palliative Care services	Palliative Care services module
Psycho-geriatric services	Mental Health Older Persons service

To this end, the Geriatric services module contains nine sections which should be read collectively, and includes:

Section 1: Emergency Geriatric Care services (Levels 1 to 6)

Section 2: Geriatric Acute Inpatient services (Levels 3 to 6)

Section 3: Geriatric Ambulatory services (Levels 1 to 6)

Section 4: Geriatric Cognitive Impairment services (Levels 4 to 6)

Section 5: Geriatric Consultation Liaison services (Levels 3 to 6)

Section 6: Geriatric Evaluation and Management services (Levels 3 to 6)

Section 7: Geriatric Interim Care services (Levels 2 to 3)

Section 8: Geriatric Rehabilitation services (Levels 3 to 6)

Section 9: Ortho-geriatric services (Levels 4 to 6).

Special note: Patients seeking any type of geriatric service may be carers too.

Section 1: Emergency Geriatric Care

Existing models of emergency care were designed for the acutely injured and ill patient rather than medically complex and functionally impaired older persons.[4] It is important emergency services, the front door of healthcare facilities, have access to resources to assist them assess and meet the needs of older people. Early access to the advice and care of a specialist geriatric team is important for older people presenting to hospital via emergency. All older persons are entitled to:

- equitable access to acute health care
- participation in decision-making related to their care
- respect for their dignity and autonomy
- involvement of family and carers in their care, where desired by the patient.[5]

The key features for emergency services for older persons, in either Emergency Care Centres (Level 1 to 3 emergency services) or Emergency Departments (Level 4 to 6 emergency services) are as follows:

- appropriate mechanisms to assist in the identification and management of older people with complex co-morbidities and at risk of multiple presentations
- access to specialist advice on geriatric conditions
- multidisciplinary assessments as appropriate
- discrete, and where possible, separate areas associated or co-located within emergency care centres / departments which provide an appropriate environment for the multidisciplinary assessment and management of older people, their families and carers, and to facilitate liaison with referring general practitioners, service providers, families and carers
- processes to refer older people into appropriate treatment and care alternatives which may include referral to community health services or short stay observation wards with multidisciplinary coordination and input.[4,5]

Section 2: Geriatric Acute Inpatient services

Older people are commonly treated in beds in acute wards. This may take the form of a designated unit for the acute care of the elderly, or in designated beds for older people within general wards, or admission under the care of other specialty services. The approach taken depends on a combination of factors including:

- the size of the service
- caseload
- availability of and/or access to specialist geriatric medicine staff and other multidisciplinary specialist staff with expertise in geriatric care
- in-hospital patient flows e.g. from acute to sub-acute services.

Patient care may be managed by a lead geriatrician, a geriatrician in conjunction with other medical specialists and a multidisciplinary team, or care may be overseen by other specialists with geriatric consultation as required. Regardless of the model, principles for the care of older people should form part of the protocols and practices for treatment, with these principles including:

- a positive attitude to aging
- a positive and active approach to illness in old age
- optimising outcomes by promoting functional independence
- early intervention
- thorough assessment including mechanisms for identification and management of older people's physical, mental, functional and social status
- accurate diagnosis
- a problem orientated approach
- goal setting
- a multidisciplinary team approach to patient care
- involvement of family and carers
- recognition geriatric rehabilitation is an essential element of geriatric medicine
- improving quality of life.[6]

In addition, the document–Age-friendly principles and practices: Managing older people in the health service environment–developed by the Care of Older Australians Working Group (COAWG) on behalf of the Australian Health Minister's Advisory Council (AHMAC) provides a framework for health services to use for the management of older people in acute and non-acute settings. Geriatric acute inpatient care requires a clear focus on the early identification and treatment of geriatric syndromes, early mobilisation, and the prevention of functional decline. Emerging substitution models such as Hospital in the Home (HITH) and Hospital in the Nursing Home are also examples of this type of care.

For the purposes of this module, the term:

- **Hospital in the Home (HITH) care** refers to care in a patient's permanent or temporary residence (including a nursing home) for conditions requiring clinical governance, monitoring and/or input that would otherwise require treatment in the traditional inpatient hospital bed. The admission criterion is governed by the authorising officer and as such the HITH program is focused exclusively on admitted care substitution.[7]

Section 3: Geriatric Ambulatory services

Geriatric ambulatory services can be delivered in hospital-based, community centre-based or home-based settings. They may provide clinic- and/or home-based comprehensive

assessment and consultation for older people with complex medical, cognitive and/or functional needs who are no longer inpatients. Staff may provide education to patients, carers and/or health care providers. Ideally these services are provided as part of an integrated, geographically-based geriatric service.

For the purposes of this module, the terms:

- **community centre-based care** refers to care provided to patients in a healthcare environment other than an inpatient hospital setting.
- **home-based care** refers to care provided in the patient's permanent or temporary residence, Residential Aged Care Facility, hotel, prison and boarding house.7

General geriatric ambulatory clinics may provide one or a combination of geriatric-type services such as falls prevention or pain management. Referral to speciality physicians and specialised geriatric ambulatory services may also be appropriate for inpatients where required. Multidisciplinary teams may be involved in the provision of services. Patients may attend for multiple occasions of service either on an ongoing basis or attendance may be time limited.

Specialised geriatric ambulatory clinics may include: Cognitive Disorder services, Continence, Falls and Mobility, Movement Disorders, Ortho-geriatric, Pain Management, Rehabilitation, Osteoporosis, and Healthy Living clinics.

Specific examples of these clinic services include:

- Cognitive Disorder services providing specialist referral services for early identification and support of older people with cognitive deficits or memory loss as well as diagnostic evaluation, assessment of the impact of impairment within the home or other environment, education, information and referral to other services.
- Continence clinics providing an accessible, multidisciplinary clinical service specialising in incontinence and other bladder and/or bowel function difficulties, as well as assessment, diagnosis, management, education and support to improve continence for patients.
- Falls and mobility clinics providing specialist multidisciplinary services which focus on the assessment and management of patients with falls, mobility and balance problems, commonly providing time limited, specialist intervention to the patient and advice, and referral to mainstream services for ongoing management as well as education and training to patients, carers and health professionals.
- Pain management clinics providing specialised referral services, mainly for older patients who continue to be troubled by chronic non-malignant pain despite usual medical and community care, with multidisciplinary services provided to address the medical, physical and psychological aspects of pain.[8]

Geriatric ambulatory services may also be provided from a **day hospital** (also known as Day Therapy, a Wellness Centre or Day Rehabilitation in Hospital) which consist of a designated area where inpatient and outpatient care connects. A range of therapy options can be provided.

Section 4: Geriatric Cognitive Impairment services

Quality care for the older patient with cognitive impairment should be core business for all healthcare services. Services for assessment and management of cognitive impairment (dementia, delirium, and associated behavioural disturbances) are typically incorporated and provided in geriatric services in a variety of models. These range from risk management incorporating age friendly principles and practices, consultation liaison services through to specialist units. Failure to adopt these services may lead to staff burnout.

Identification of strategies and appropriate management of these patients should be appropriate to the individual service setting and/or area i.e. acute ward, GEM unit or psycho-geriatric unit, knowledge base, and the protocols of the service.

Note: Community-based cognitive improvement services have been addressed in the Geriatric Ambulatory services section of this module.

Section 5: Geriatric Consultation Liaison services

This type of service involves geriatric teams providing assessment, consultation and treatment for older patients. For the purposes of this module, geriatric consultation liaison services are delivered for admitted patients only. The key features of this type of service are:

- comprehensive medical assessment and determination of a management / treatment plan, normally conducted by a geriatrician
- teams varying in composition but usually including a geriatrician, nurses and allied health professionals, providing comprehensive assessment of physical, emotional, functional and social status in older people
- assessments typically including measurement of mobility and functional status, cognitive testing, mental state examinations, psychological screening, and evaluation of common geriatric problems e.g. risk of falls, incontinence, and polypharmacy
- recommendations regarding prevention and management of common geriatric syndromes, functional impairments, and other problems
- plans for rehabilitation and/or appropriate discharge planning
- follow-up until the patient is discharged
- expertise in geriatric care throughout the hospital–there is a greater opportunity to reach a larger number of patients when the consultation team is not single unit based and there are no bed limits
- links to the existing/referring service e.g. surgical team (modified from Shojania et al).[9]

Models are more likely to be effective when there is direct control over the clinical recommendations.[3] The extent to which the team is involved in ongoing management may depend on referral processes, screening processes, local models of care (i.e. consultancy only, shared care, or direct control), protocols, and resources to provide interventions and implementations.

Section 6: Geriatric Evaluation and Management services

Geriatric Evaluation and Management (GEM) is defined as care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multidisciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative timeframes. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician; or
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.[10]

The key features of this type of service are:

- a multidisciplinary team providing management and regular assessments against a management plan using a recognised functional assessment measure
- detailed treatment plans and attention to the rehabilitative / restorative needs of older patients
- multidisciplinary team rounds and patient-centred team conferences involving the patient and family/carer
- direct control over the implementation of team recommendations
- comprehensive discharge planning
- services provided across the hospital or in separate GEM units which may be separate hospital wards that have been redesigned or have provisions made to facilitate care of the geriatric patient e.g. flooring, bed layout, bathroom facilities
- may be able to take direct referrals and/or admit from the community.[11]

Emerging substitution models such as Geriatric Evaluation and Management in the Home (GEMITH) can also be included in this type of care.

Section 7: Geriatric Interim Care services

Also known as **care-awaiting placement** (CAP), geriatric interim care services are less intense than acute or sub-acute care with respect to investigations undertaken and therapy provided. Older persons no longer require acute or sub-acute care and are primarily awaiting transition care or residential nursing home placement. Alternatively patients may have completed their acute and/or sub-acute periods and not yet be ready to commence rehabilitation e.g. prolonged non-weight-bearing periods post orthopaedic injury or repair.

However they are still managed by a geriatric service to continue to aim for suitable treatment outcomes and an appropriate living environment. The duration of such care

depends on the needs of the individual, their social circumstances, and on availability of community care or residential care services.

Section 8: Geriatric Rehabilitation services

Geriatric rehabilitation is an integral component of geriatric medicine and may operate under the control of the geriatric service or may be co-located with another service or unit. It may also occur in Day Hospitals and home- or centre-based community programs.

For the purposes of the geriatric services module, geriatric rehabilitation care is care of the older person in which the clinical intent or treatment goal is to improve the functional status of the older person with an impairment, disability or handicap. It includes care provided:

- in a designated geriatric rehabilitation unit; or
- in a designated geriatric rehabilitation program (or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation; or
- under the principal clinical management of a geriatrician.[11]

Geriatric rehabilitation uses the same principles as described for rehabilitation, namely:

- multidisciplinary rehabilitation plan
- patient-centred goal setting
- indicative timeframes evaluated by a periodic assessment using a recognised functional assessment measure.[10]

Geriatric rehabilitation features include:

- comprehensive geriatric assessment
- structured, active rehabilitation for specific medical conditions and/or geriatric syndromes
- admissions may be from the community, via Emergency or from other inpatient units
- management of acute illness in older people undergoing rehabilitation
- regular case conferences and goal focussed planning
- multidisciplinary family meetings, as required.

Section 9: Ortho-geriatric services

Ortho-geriatric care is medical care for older patients with orthopaedic disorders provided collaboratively by orthopaedic services and programs catering for older people. It can be provided as part of a general geriatric service, or as a specific program within services or within another department e.g. orthopaedic department.

Features include:

- effective treatment provided through cooperation between a range of health professionals (multidisciplinary teams that include geriatricians)
- assessment and management of medical co-morbidities

- early definitive surgery where possible and minimal immobilisation
- rehabilitation including early mobilisation following surgery
- ongoing rehabilitation as required
- secondary prevention and minimisation of risk factors.[12]

Service networks

In addition to the requirements outlined in the Fundamentals of the Framework, specific network requirements include:

- establishment of regional geriatric services linking inpatient, outpatient and community services, inclusive of the following features:
  - central referral points
  - access to Aged Care Assessment Teams (ACATs), assessment and rehabilitation programs, and community support services
  - case management may be used
  - education and support to general practitioners, aged care facilities and community service providers
  - advocacy and provision of professional leadership and support.
- documented processes with community support services to facilitate timely discharge from hospital and implementation of required support to enable return to living at home (in the absence of established regional geriatric services).

The service networking medium of **telehealth** is actively encouraged. Geriatric telehealth services offer assessment and treatment to individual patients irrespective of their location e.g. other facilities, community settings, or the home. Models of service delivery for providing geriatric telehealth services include consultancy by telephone, telehealth, teleradiology, telepharmacy, and/or telechemotherapy, and referral as appropriate. Fundamentally, the patient and service provider are not in the same physical location.

A geriatric telehealth service may include:

- development of geriatric service capacity within the 'provider' regional and/or metropolitan service centre
- base level geriatric service development in smaller 'host' hospitals
- deployment of a local nurse for case preparation, care coordination and hosting
- case preparation using an online structured assessment system
- development of rural outreach services to provide inpatient consultation, and/or outpatient and community services
- weekly video-consultation rounds conducted by a geriatrician
- a weekly multidisciplinary case conference.13

Service requirements

In addition to the requirements outlined in the Fundamentals of the Framework, specific service requirements include:

- systematic approach to assessing the older person via comprehensive geriatric assessment
- clear focus on the early identification and treatment of geriatric syndromes, early mobilisation, and prevention of functional decline
- carer involvement in formulating and communicating care / management plans to improve the relay of information
- secondary and tertiary preventive interventions such as balance classes
- availability of Advance Care Plan / Directive and end of life care instruction
- ward design to accommodate older patient's physical, cognitive and functional requirements as well as configured to be more age friendly with capacity for normalisation e.g. meals taken in a dining room rather than at the bedside, and easy access to a gymnasium and assistive equipment
- all areas should be accessible to wheelchairs and mobility aids including electric scooters
- access to Diversional Therapy and Music Therapy to keep people occupied and cognitively engaged
- regular multidisciplinary case conferencing and periodic assessment of cognitive and physical status using a suite of standardised assessment instruments
- early and focused discharge planning
- a therapy timetable may be accessible to staff and patients
- relevant clinical indicator data provided to satisfy accreditation and other statutory reporting obligations.

Workforce requirements

In addition to the requirements outlined in the Fundamentals of the Framework, specific workforce requirements include:

- early involvement of the multidisciplinary team soon after admission.

Risk considerations

In addition to the requirements outlined in the Fundamentals of the Framework, risk considerations in relation to geriatric services include:

- older people often have more complex medical and social issues than other patients, and higher prevalence of disability[4]
- older people are at risk of adverse outcomes during hospitalisation including but not limited to functional decline, falls, pressure areas, incontinence, malnutrition, medication errors, delirium and loss of morale

- frail older people experience increased risk of falling and sustaining injury as a result of falling
- older orthopaedic patients have higher rates of medical complications such as delirium and are more likely to require inpatient rehabilitation following fracture.

Section 1: Emergency Geriatric Care services

Please note: This section should be read in conjunction with the Emergency services module (for adults). These minimum criteria by capability level apply only where dedicated Emergency geriatric care services have been established.

Emergency geriatric care

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Service description	• provided in a Level 1 emergency care centre. • aim of older person emergency care service is alleviating suffering while providing prompt diagnosis of life-threatening conditions to promote quality of life at same time as respecting	• provided in a Level 2 emergency care centre. • service inclusive of older person-friendly emergency service adopting evidence-based and coordinated inter-professional approach to initiation of care, disposition planning and referral for post-	• typically provided in a Level 3 emergency care centre but could be provided in lower level emergency care centres.	• provided in either a Level 3 emergency care centre or Level 4 emergency department with functional assessment of the older person undertaken involving multidisciplinary team.	• provided in a Level 5 emergency department. • service inclusive of collaborative approach between geriatric and emergency multidisciplinary teams, optimising older person's episode of care in emergency. • trauma team activation	• provided in a Level 5 or Level 6 emergency department. • distinct model of care in place for older person presenting to emergency department.

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	patient and family autonomy.	emergency follow-up.			triggered by age rather than vital signs.	
Service requirements	As per module overview, plus: • perform gerontic-focused history and physical examination on all older people presenting to emergency as serious surgical or medical illness may present in subtle or atypical way in older persons. • establish availability of Advance Care Plan / Directive to guide end-of-life decisions and discuss whether this remains consistent with patient and/or	As per Level 1, plus: • screening for at-risk older persons routinely performed to identify those who would benefit from focused geriatric and functional assessment.	As per Level 2, plus: • contemplate hospital admission or alternative support in absence of identifiable medical cause if older person cannot functionally manage in community.	As per Level 3, plus: • targeted screening for at-risk older persons and referral on to specialist geriatric teams. • access to hospital substitutive care for older persons. • inter-professional and multidisciplinary education on geriatric principles provided to emergency service staff to improve confidence in dealing with older patients and increase	As per Level 4, plus: • use of suitable older person's assessment tools during triage. • timely input from specialist geriatric services including Telehealth support by geriatricians. • provides hospital substitutive care for older persons including those residing in residential care facilities. • optimising of physical environment to allow for	As per Level 5, plus: • access to geriatrician-led consultation-liaison service. • access to trauma service inclusive of geriatricians, orthopaedic surgeons, neurosurgeons and allied health, led by geriatric trauma surgeons. • strong links with primary and residential care.

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	family instructions. • access to Telehealth to obtain advice about health care for older patients.			appropriate decision making. • access to Telehealth supported by staff with expertise in geriatric care to obtain advice about health care for older patients.	assistance older patients likely to require such as help with toileting,	
Workforce requirements	As per module overview, plus access to one or more of following: **Medical** • a geriatrician during business hours. **Nursing** • specialist trained RNs to perform geriatric assessment. **Allied health**	As per Level 1 plus: **Allied health** • access to Social Worker and/or other relevant allied health professional during business hours.	As per Level 2	As per Level 3	As per Level 4, plus: • emergency staff coordinate management of all aspects of older persons health needs, not just presenting complaint. **Medical** • access to on-site geriatrician during business hours. **Nursing**	As per Level 5 plus: **Medical** • access 24/7 to emergency medicine specialist with special interest in geriatric emergency medicine. • access 24/7 to geriatrician. **Nursing** • suitably qualified and experienced

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	• Pharmacist during business hours. **Other** • Aboriginal and Torres Strait Islander health workers, as required.				• access 24/7 to suitably qualified and experienced RN/s to advise on meeting specific care needs of older patients. • access to nursing support roles external to emergency service e.g. Community Hospital Interface Program (CHIP) RN or nurse navigator. **Allied health** • access during business hours to Occupational Therapist, Pharmacist, Physiotherapist, Social Worker and Speech Pathologist.	RN/s on each shift who understand specific care needs of older patients. **Allied health** • on-site access 7-days per week to Occupational Therapist, Physiotherapist and Speech Pathologist during business hours. • access–24 hours–to Pharmacist and Social Worker. **Other** • care coordination inclusive of community-based health professionals.

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Specific risk considerations	• older people present with more complex medical conditions and social circumstances.[5] • older people may be less able to communicate with emergency staff due to cognitive impairment, visual or hearing impairment and/or delirium.[4]	As per Level 1	As per Level 1	As per Level 1	As per Level 1	As per Level 1

Support services requirements for emergency geriatric care

	Level 1		Level 2		Level 3		Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible
Anaesthetic					3		4		5		6	

	Level 1		Level 2		Level 3		Level 4		Level 5		Level 6	
Emergency	1		2		3		4		5		6	
Medical		1		2		3	4		5		5	
Medical imaging		1		1	1		4		5		5	
Medication		1		2	3		4		5		5	
Mental health older person ambulatory		1		2		2		3		5		5
Mental health older person acute inpatient		2		2		2		3	4		5	
Pathology		2		2		3		4	4		5	
Surgical				2		3	4		5		6	

Table note: On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy and/or outreach.

Section 2: Geriatric Acute Inpatient services

Please note: This section should be read in conjunction with the Medical and Surgical services modules (for adults) Emergency geriatric care

Geriatric acute inpatient services

	Level 3	Level 4	Level 5	Level 6
Service description	• provides hospital-based care to older persons across a range of clinical settings.	• provides access during business hours to multidisciplinary geriatric consultancy service, led by specialist geriatrician and inclusive of suitably qualified and experienced nursing and/or allied health staff. • processes in place to facilitate early referral of older patient to multidisciplinary geriatric consultancy service.	• provides access–24hours –to multidisciplinary geriatric consultancy service, led by specialist geriatrician working closely with suitably qualified and experienced nursing and/or allied health staff. • processes in place beginning in Emergency to facilitate early referral of older patient to multidisciplinary geriatric consultancy service. • mechanisms in place to review quality of services provided to older patients in acute inpatient wards.	• provides on-site multidisciplinary geriatric consultancy service, led by specialist geriatrician working closely with suitably qualified and experienced nursing and allied health staff. • may provide direct admission for older persons presenting to hospital with primarily functional issues or ADL difficulties and no major acute illness to geriatric assessment unit. • may provide shared care model between admitting consultant and specialist geriatrician.

	Level 3	Level 4	Level 5	Level 6
				• lead clinician may be a geriatrician.
Service requirements	As per module overview, plus: • access to risk screening, prevention and management protocols for common problems affecting older people such as falls, pressure areas, incontinence, malnutrition and medication errors.	As per Level 3, plus: • routine use of risk screening, prevention and management protocols for common problems affecting older people such as falls, pressure areas, incontinence, malnutrition and medication errors. • access to newer models of care such as hospital in the home and	As per Level 4, plus: • focus on maintaining independence of older patient in safe physical age-friendly environment. • may provide newer models of care such as hospital in the home and hospital in the nursing home.	As per Level 5, plus: • provides comprehensive assessment and restorative care in appropriate environment. • provides newer models of care such as hospital in the home and hospital in the nursing home.
Workforce requirements	As per module overview, plus access to one or more of following (visiting basis or outreach services): **Medical** • registered medical practitioner. **Nursing** • RN/s suitably qualified and experienced in care of the older person. **Allied health**	As per Level 3, plus: **Medical** • access to a geriatrician. **Nursing** • on-site RN/s suitably qualified and experienced in care of the older person. **Allied health** • access to allied health team including Dietician, Neuropsychologist, Occupational Therapist,	A per Level 4, plus: **Medical** • on-site geriatrician. **Nursing** • access to RN/s with specialist geriatric care skills. **Allied health** • dedicated allied health team during business hours including Dietician, Occupational Therapist, Pharmacist, Physiotherapist,	As per Level 5, plus: **Medical** • on-site geriatrician team. • on-site access to range of registered medical specialists. **Nursing** • onsite RN/s with specialist geriatric care skills.

	Level 3	Level 4	Level 5	Level 6
	• Occupational Therapist, Pharmacist, Physiotherapist and Social Worker. **Other** • Aboriginal and Torres Strait Islander health workers, as required.	Pharmacist, Physiotherapist, Psychologist, Social Worker and Speech Pathologist. **Other** • access to Aboriginal and Torres Strait Islander health workers, as required.	Social Worker and Speech Pathologist to visit and/or treat and/or provide consultancy advice on treatment of older acute care inpatients. **Other** • Aboriginal and Torres Strait Islander health workers, as required.	
Specific risk considerations	Nil	Nil	Nil	Nil

Support services requirements for geriatric acute inpatient services

	Level 3		Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible
Anaesthetic		3		4	5		5	
Medical	3		4		5		6	
Medical imaging	3		4		4		5	

	Level 3		Level 4		Level 5		Level 6	
Medication	3		4		5		5	
Mental health older person ambulatory		3		4		4		4
Mental health older person acute inpatient				4		4		4
Palliative care		3		4		5		5
Pathology		3		4	4		5	
Perioperative (relevant sections)					5		5	
Surgical				4		5		6

Table note: On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off- site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy and/or outreach.

Section 3: Geriatric Ambulatory services

Geriatric ambulatory services

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Service description	• provided by minimum sole practitioner generalist service. • may include access to geriatric ambulatory services via Telehealth.	• provided by generalist service as part of mix of services provided. • access to geriatric ambulatory services via Telehealth or visiting service.	• provided by designated geriatric ambulatory service which includes access to inpatient beds.	• provided by designated geriatric ambulatory service with access to some sub-specialty ambulatory and inpatient geriatric services.	• provided by geriatrician-led designated service including access to a range of sub-specialty ambulatory and inpatient geriatric services.	• full range of geriatric ambulatory services provided.
Service requirements	As per module overview, plus: • clinic-based assessment and consultation. • access to inpatient care as required. • access to Aged Care Assessment Team (ACAT) service.	As per Level 1, plus: • assessment and consultation may be clinic- or home-based.	As per Level 2, plus: • access to inpatient substitution program.	As per Level 3 plus: • access to a range of clinics. • access to multidisciplinary team for case conferencing.	As per Level 4, plus: • access to Geriatric Day Hospital. • co-located specialist geriatric rehabilitation service with inpatient gymnasium and specialist staff.	As per Level 5, plus: • co-located Geriatric Day Hospital.

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
					• co-located multidisciplinary clinics. • specialist inpatient substitution program such as RITH or GEMITH. • increasing use of distant monitoring and/or web-based monitoring.	
Workforce requirements	As per module overview, plus access to (visiting basis or outreach services): **Medical** • periodic cover or Telehealth coverage by geriatrician. **Nursing** • suitably qualified and experienced nurse/s.	As per Level 1, plus: **Medical** • access to a geriatrician on a scheduled basis. **Nursing** • on-site suitably qualified and experienced nurse/s. **Allied health** • access to allied health	A per Level 2, plus: • specialist visiting or resident multidisciplinary team. **Medical** • access to a geriatrician at least weekly. **Allied health** • access to Dietician, Neuropsychologist Occupational	As per Level 3, plus: **Medical** • visiting geriatrician. **Nursing** • suitably qualified and experienced acute and/or non-acute and/or palliative care RN/s and/or RN/s with mental	As per Level 4, plus: **Medical** • geriatrician within ambulatory service. **Nursing** • nurse manager (however titled) of Geriatric ambulatory service. **Allied health**	As per Level 5, plus: **Medical** • access to geriatrician team. **Nursing** • RN/s with advanced training in geriatric medicine. **Allied health**

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	Allied health • periodic cover or cover by Telehealth. **Other** • Aboriginal and Torres Strait Islander health workers, as required.	professionals as required.	Therapist, Physiotherapist, Podiatrist, Psychologist, Speech Pathologist and Social Worker.	health qualifications. **Allied health** • on-site Occupational Therapist, Physiotherapist and Social Worker within ambulatory service.	• access 5 day per week to other relevant allied health multidisciplinary team.	• access 7 day per week to other relevant allied health multidisciplinary team.
Specific risk considerations	• risk assessment relevant to ambulatory services. • lone worker policy.	As per Level 1	As per Level 1	As per Level 1	As per Level 1	As per Level 1

Support services requirements for geriatric ambulatory services

	Level 1		Level 2		Level 3		Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible
Medical		1		2		3		3		3		3

	Level 1		Level 2		Level 3		Level 4		Level 5		Level 6	
Medical imaging		4		4		4		4		4		4
Medication		1		2		3		3		3		3
Palliative care		1		2		3		4		5		5
Pathology		1		2		2		2		2		2

Table note: On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 4: Geriatric Cognitive Impairment services

Geriatric cognitive impairment services

	Level 4	Level 5	Level 6
Service description	• provides consultation-liaison service during business hours for hospitalised older patients.	• designated specialised cognitive impairment service. • on-site access to specialist unit which also encompasses general geriatric beds. • ability to implement needs based co-location strategies e.g. converting 2 to 4 bed bay into satellite specialist unit. • accepts referrals from lower level services.	• distinct model of care in place for treatment of patients with cognitive impairment and high risk behavioural symptoms. • designated cognitive impairment service including designated beds within designated unit. • specialised staff provide consultation liaison service to facilities within and/or beyond their catchment.
Service requirements	As per module overview, plus: • access to consultation liaison support provided by specialised staff. • coordinated response to behavioural emergencies.	As per Level 4, plus: • on-site access to appropriate built environment and level of patient supervision. • specialist admission criteria with capacity for referral directly from community and/or emergency and/or other inpatient unit to inpatient unit. • specialised cognitive impairment service provides consultation liaison support, staff education, and contributes to organisation-wide quality improvement processes.	As per Level 5, plus: • access to cognitive assessment and management unit.

	Level 4	Level 5	Level 6
Workforce requirements	As per module overview, plus: • access to generalist multidisciplinary team. **Medical** • access to geriatrician and older person's psychiatry. **Nursing** • suitably qualified and experienced nurse/s. **Allied health** • access to Dietician, Occupational Therapist, Physiotherapist, Psychologist, Social Worker and Speech Pathologist. **Other** • Aboriginal and Torres Strait Islander health workers, as required.	As per Level 4, plus: • designated position managing the service. **Medical** • on-site geriatrician. **Nursing** • nurse manager (however titled) for geriatric cognitive impairment service. • one or more specialist nurse roles designated to cognitive impairment service. **Allied health** • on-site during business hours relevant allied health multidisciplinary team. • access to Neuropsychology.	As per Level 5, plus: **Medical** • on-site access to geriatrician team. • access to older person's psychiatry. **Nursing** • RN/s with advanced training in geriatric medicine and older person's mental health care. **Allied health** • access after-hours to relevant allied health multidisciplinary team. • Neuropsychologist part of integrated multidisciplinary team.
Specific risk considerations	increased potential for staff exposure to acts of violence such as physical assault, verbal abuse, threats and/or aggressive behaviours.	As per Level 4	As per Level 4

Support services requirements for geriatric cognitive impairment services

	Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible
Anaesthetic		3		4		5
Medical	4		4		4	5
Medical imaging	2		2		3	
Medication	3		4		5	
Mental health older person ambulatory		4		5	5	
Mental health older person acute inpatient		4		5	5	
Palliative care		4		5		5
Pathology	2		3		4	

Table note: On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 5: Geriatric Consultation Liaison services

Geriatric Consultation Liaison services

	Level 3	Level 4	Level 5	Level 6
Service description	• RN-led geriatric triage, assessment and consultancy service. • provides assessment and targeted intervention for hospitalised older patients where local expertise is not available.	• access to geriatric triage, assessment and consultancy service provided by consultant geriatrician or other suitably qualified and experienced health professional.	• designated on-site geriatrician-led geriatric triage, assessment and consultancy service. • provides multidisciplinary assessment and targeted intervention for acutely hospitalised older patients.	• provides inpatient ACAT assessment as part of designated on-site geriatrician-led geriatric triage, assessment and consultancy service.
Service requirements	As per module overview, plus: • may include either consultancy by telephone, telehealth consultation or face-to-face visitation. • may include facilitated telepharmacy and/or teleradiology services. • scope of services may be either 'ad hoc' needs-based service, regular service at set times over an agreed period of time, or fully established service involving as many MDT members as available at host service.	As per Level 3, plus: • structured geriatric assessment.	As per Level 4, plus: • triage, structured geriatric assessment, diagnosis and management advice. • delivery of set weekly sessions at mutually agreed time slots.	As per Level 5

	Level 3	Level 4	Level 5	Level 6
	• patient remains under care of the home team.			
Workforce requirements	As per module overview, plus: **Medical** • access to geriatrician. **Nursing** • on-site suitably qualified and experienced RN/s during business hours.	As per Level 3, plus access to one or more of following (visiting basis or outreach services): **Medical** • geriatrician. **Nursing** • suitably qualified and experienced RN/s. **Allied health** • access to relevant suitably qualified and experienced allied health team.	As per Level 4, plus: **Medical** • on-site geriatrician team. • access to range of registered medical specialists. **Nursing** • on-site suitably qualified and experienced RN/s.	As per Level 5, plus: • on-site ACAT assessors and delegates.
Specific risk considerations	potential for service interruption due to technical issues where telehealth services are key mode of delivery.	As per Level 3	As per Level 3	As per Level 3

Support services requirements for geriatric consultation liaison services

	Level 3		Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible
Anaesthetic		3		3		4		5
Medical		3		4		5		6
Medical imaging		3		4		4		5
Medication		3		4		5		5
Mental health older persons ambulatory		3		4		4		4
Mental health older persons acute inpatient		3		4		4		4
Pathology		3		4		4		5
Surgical				3		4		5

Table note: On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 6: Geriatric Evaluation and Management (GEM) services

GEM services

	Level 3	Level 4	Level 5	Level 6
Service description	• provided in either general ward or designated geriatric unit. • primary focus of care is restoration of physical and cognitive functioning or prevention of further functional decline. • primary diagnosis often unclear. • often complex care needs include multi-morbidity and psychosocial problems. • physical frailty often present. • patients usually have impaired decision-making. • patient more likely to require ongoing post-discharge community-based services or residential care.	• designated GEM service and/or unit.	• specialist geriatrician-led designated GEM service and/or unit.	• provides care to most complex patients. • typically located in large hospital providing range of clinical sub-specialties including a trauma service, high level orthopaedic service and various chronic disease management programs. • accepts referrals from lower level services. • may include statewide and/or interstate superspecialty service.
Service requirements	As per module overview, plus:	As per Level 3, plus:	As per Level 4, plus:	As per Level 5, plus:

	Level 3	Level 4	Level 5	Level 6
	• access to other designated geriatric services over and above GEM service.	• includes some designated geriatric services over and above GEM service. • access to dining / eating area. • access to gymnasium. • access to community-based restorative care e.g. home- or centre-based therapies and/or designated outreach service.	• includes most designated geriatric services over and above GEM service. • integrated intake, assessment and referral service. • access to geriatric rehabilitation service. • access to hospital substitution such as GEMITH. • access to GEM outpatient clinics including memory, continence and falls clinics. • access to on road driving assessment.	• includes all designated geriatric services over and above GEM service. • provides hospital substitution such as GEMITH. • designated outreach service team. • on road driving assessment.
Workforce requirements	As per module overview, plus (visiting basis or outreach services): **Medical** • registered medical practitioner with interest in geriatric care. • access to registered medical specialist geriatrician. **Nursing** • suitably qualified and experienced nurses.	A per Level 3, plus: **Nursing** • nurse manager (however titled) in GEM unit. • access to suitably qualified and experienced acute and/or non-acute and/or palliative care RN/s and/or RN/s with mental health qualifications. • nurse-led wound management service.	As per Level 4, plus: • access to specialised multidisciplinary wound management service. **Medical** • on-site access to registered medical specialist geriatricians. • access to psycho-geriatrician. • access to range of registered medical specialists including neurology, urology,	As per Level 5, plus: on-site specialised multidisciplinary wound management service. **Medical** • on-site access to geriatrician team. **Nursing** • access to RN/s with advanced training in geriatric medicine.

	Level 3	Level 4	Level 5	Level 6
	Allied health • Occupational Therapist, Pharmacist, Physiotherapist and Social Worker or advanced allied health professional/s. **Other** • Aboriginal and Torres Strait Islander health workers, as required.	**Allied health** • access to allied health including Dietician, Neuropsychologist, Occupational Therapist, Pharmacist, Physiotherapist, Psychologist, Social Worker and Speech Pathologist.	orthopaedics, palliative care, pain. **Allied health** • designated allied health team including Dietician, Neuropsychologist, Occupational Therapist, Pharmacist, Physiotherapist, Psychologist, Social Worker and Speech Pathologist.	
Specific risk considerations	patients more likely to be discharged with mutually agreed post-discharge safety risks.	As per Level 3	As per Level 3	As per Level 3

Support services requirements for GEM services

	Level 3		Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible
Anaesthetic		3		3		4		5
Medical imaging	3		3		4		4	

	Level 3		Level 4		Level 5		Level 6	
Medication	3		4		5			
Mental health older persons ambulatory		3		4		5		5
Mental health older persons acute inpatient		3		4		5		5
Palliative care		3		4		5		5
Pathology	3		4		4		5	

Table note: On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 7: Geriatric Interim Care services

Please note: Geriatric interim care services ideally should not be provided in the hospital environment however on occasions this service may be necessary. Younger people may also require interim care services.

Geriatric interim care services

	Level 2	Level 3
Service description	• provided for persons who have finished their acute and subacute care and are awaiting community options, or in case of non-weight bearing patients, return to (Geriatric) Rehabilitation and/or acute care. • typically delivered in general medical wards in rural hospitals.	• capacity to provide inpatient non-acute but complex patient care in geriatric unit or general medical ward typically for patients waiting next phase of treatment e.g. non-weight-bearing patients. • patients may have challenging behaviours and/or other complex care needs e.g. ventilated patients or patients requiring tracheostomy care, bariatric care, parental nutrition and/or PEG feeding. • timely back transfer of stabilised patients to service closer to their home. • option to outsource service to third party provider, especially within larger regional and metropolitan areas.
Service requirements	As per module overview, plus: • various forms of patient transfer apparatus.	As per Level 2, plus: • provide lower level services with a patient management plan when back transferring patients. • provide staff training to local services where needed to enable patient back transfer.

	Level 2	Level 3
		• provide advice to lower level services in relation to patient care, equipment requirements and other care-related matters.
Workforce requirements	As per module overview, plus access to two or more of following (visiting basis or outreach services): **Medical** • general practitioner (GP). • registered medical specialist geriatrician/s. **Nursing** • suitably qualified and experienced nurses. **Allied health** • Physiotherapist and Social Worker. **Other** • Aboriginal and Torres Strait Islander health workers, as required. • ward-based non-regulated personal care staff.	As per Level 2, plus: **Medical** • on-site registered medical practitioner. **Nursing** • access–24 hours–to minimum two nurses; one being a registered nurse. **Allied health** • access–during business hours–to relevant allied health staff. **Other** • Aboriginal and Torres strait Islander health workers, as required. • access–24 hours–to unit-based non-regulated personal care staff.
Specific risk considerations	Nil	Nil

Support services requirements for Geriatric interim care services

	Level 2		Level 3	
	On-site	Accessible	On-site	Accessible

	Level 2		Level 3	
Anaesthetic				3
Medical		2	2	
Medical imaging		2	3	
Medication	2		3	
Mental health older persons ambulatory		2		3
Mental health older persons acute inpatient		2		3
Palliative care		2		3
Pathology		2		3
Surgical		2		2

Table note: On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 8: Geriatric Rehabilitation services

Please note: This section should be read in conjunction with the Rehabilitation services module.

Geriatric rehabilitation services

	Level 3	Level 4	Level 5	Level 6
Service description	• inpatient unit where increased period of treatment and recovery time is provided to achieve maximum potential functional gain. • patients usually expected to return to their prior living arrangements at completion of episode of geriatric rehabilitation subject to their level of independence. • patients usually have specific and readily recognised cause for recent change in their functional status (e.g. suffered from acute stroke, had an amputation or orthopaedic procedure,	• geriatric unit where increased period of treatment and recovery time is provided to achieve maximum potential functional gain. • minimisation of ward and/or inter-facility patient transfers.	• designated geriatrician-led unit increased period of treatment and recovery time is provided to achieve maximum potential functional gain.	• highly specialised designated geriatrician-led unit providing services to patients with highest complexity and specialised geriatric rehabilitation need.

	Level 3	Level 4	Level 5	Level 6
	deconditioning following acute illness). • identifiable diagnosis from outset.			
Service requirements	As per module overview, plus: • goal orientated, time limited rehabilitation care plan formulation. • access to rehabilitation space and/or area. • discharge planning and appropriate clinical handover and transfer of care to community service providers. • access to ADL support through community service providers. • telehealth arrangements with higher level geriatric rehabilitation service.	As per Level 3, plus: • on-site gymnasium. • specialised discharge planning including access to designated outpatient, home- and/or centre-based services to meet specific needs of older persons such as outpatient rehabilitation, RITH, falls and memory disorder clinics.	As per Level 4, plus: • access to GEM services. • access to amputee, vestibular and hypertonicity services. • access to pain service. • access to specialised wound service which may include stomal therapist, diabetes educator, endocrinologist, and/or vascular and plastic surgeons. • on-site designated outpatient services to meet the specific needs of older persons such as outpatient rehabilitation, falls, continence, and memory disorder clinics and/or Day Geriatric Hospital services. • integrated intake, assessment and referral service.	As per Level 5, plus: • onsite GEM service. • onsite amputee service. • access to hydrotherapy pool. • access to range of medical sub-specialty services which might include orthopaedic, neurological, vascular, general surgical and specialist medicine services. • may provide RITH service.

	Level 3	Level 4	Level 5	Level 6
			• increasing presence of advanced treatment technologies. • on road driving assessment.	
Workforce requirements	As per module overview, plus (visiting basis or outreach services): **Medical** • access to geriatrician. **Nursing** • suitably qualified and experienced nurse/s. **Allied health** • Occupational Therapist and Physiotherapist. • access to other members of allied health team, as required. **Other** • Aboriginal and Torres Strait Islander health workers, as required.	As per Level 3, plus: **Medical** • on-site registered medical practitioners. • on-site geriatrician. **Nursing** • access to suitably qualified and experienced RN/s, and/or acute, non-acute and/or palliative care RN/s, and/or RN/s with mental health qualifications. **Allied health** • access to Dietician, Occupational Therapist, Pharmacist, Physiotherapist, Speech Pathologist and Social Worker.	As per Level 4, plus: **Medical** • on-site geriatrician team. • access to a range of registered medical specialists. **Nursing** • nurse manager (however titled) in Geriatric Rehabilitation unit. • suitably qualified and experienced RN/s. **Allied health** • access to Neuropsychologist and/or Psychologist. • onsite access during business hours to Dietician, Occupational Therapist, Pharmacist, Physiotherapist, Speech Pathologist and Social Worker.	As per Level 5, plus: **Nursing** • RN /s with advanced training in geriatric medicine. **Allied health** • onsite access during business hours to specialised multidisciplinary team including Neuropsychologist, Psychologist, Orthotists and Podiatrist. • access after-hours to Occupational Therapist, Pharmacist, Physiotherapist and Social Worker.

	Level 3	Level 4	Level 5	Level 6
Specific risk considerations	patients more likely to be discharged with mutually agreed post-discharge safety risks.	As per Level 3	As per Level 3	As per Level 3

Support services requirements for geriatric rehabilitation services

	Level 3		Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible	On-site	Accessible
Anaesthetic		3		3		4		5
Medical		3		3		4		5
Medical imaging		3		3		4		5
Medication		3		3		3		3
Mental Health Older Persons Ambulatory		4		4		5		5
Mental Health Older Persons Acute Inpatient		4		4		5		5

	Level 3		Level 4		Level 5		Level 6	
Palliative care		3		4		5		5
Pathology		2		2		4		4
Perioperative (acute pain)				5		5		5
Surgical		2		3		4		5

Table note: On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers.

Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Section 9: Ortho-geriatric services

Please note: This section should be read in conjunction with the Anaesthetic, Perioperative and Surgical services modules (for adults).

Ortho-geriatric services

	Level 4	Level 5	Level 6
Service description	• patients admitted under orthopaedic surgeon with automatic geriatrician referral for all patients with # neck of femur (NOF). • 5 day per week daily patient review provided by geriatric service.	• integrated 7-day clinical service providing shared care model by orthopaedic surgeon and geriatrician with primary responsibility under orthopaedic team. • strategies in place to ensure patients presenting with # NOF receive surgical intervention within 48 hours (where patients clinical stable).	• integrated 7-day clinical service providing shared care model by orthopaedic surgeon and geriatrician with primary responsibility under geriatrician team. • on-site designated ortho-geriatric service.
Service requirements	As per module overview, plus: • access to consultation liaison ortho-geriatric service providing either on-site visitation or scheduled Telehealth sessions. • mechanisms in place to assess bone health.	As per Level 4, plus: • on-site ortho-geriatric service. • early commencement of rehabilitation as soon as practicable post-admission. • multidisciplinary ortho-geriatric case conferencing. • discharge planning undertaken by ortho-geriatric team.	As per Level 5, plus: • monitoring of compliance with treatment for osteoporosis. • outpatient clinic follow up at 3 months involving medical and RN staff.

	Level 4	Level 5	Level 6
	• weekly multidisciplinary geriatric team case conferencing.	• on-site geriatric rehabilitation service. • option for early transfer to 'step down' unit catering for non-weight bearing orthopaedic patients.	
Workforce requirements	As per module overview, plus: **Medical** • access to geriatrician. **Nursing** • suitably qualified and experienced nurse/s. **Allied health** • access to allied health professionals including Dietician, Occupational Therapist, Physiotherapist, Speech Pathologist and Social Worker, and with relevant surgical qualifications and/or experience, as required.	As per Level 4, plus: • access to suitably qualified and experienced ortho-geriatric service case manager. **Medical** • on-site geriatrician team. • on-site orthopaedic surgeon/s. **Nursing** • suitably qualified and experienced RN in charge of each shift. • other suitably qualified and experienced RN/s appropriate to service being provided. **Allied health** • ward-based 7-day Physiotherapist. • ward-based during business hours allied health team inclusive of suitably qualified and experienced Dietician, Occupational Therapist, Physiotherapist, Speech Pathologist and Social Worker. • access to Pharmacist and Prosthetist.	As per Level 5, plus: **Nursing** • designated NOF nurse responsible for case management and bone health follow up. **Allied health** • designated multidisciplinary team Physiotherapist, Speech Pathologist and Dietician. • access after-hours to Physiotherapy, Occupational Therapy and Speech Pathology service.

	Level 4	Level 5	Level 6
		Other • ward-based Personal Care Assistants and/or Wards persons to assist with service provision.	
Specific risk considerations	Nil	Nil	Nil

Support services requirements for ortho-geriatric services

	Level 4		Level 5		Level 6	
	On-site	Accessible	On-site	Accessible	On-site	Accessible
Anaesthetic	3		4		6	
Medical	4		5		6	
Medical imaging	4		4		5	
Medication	3		4		5	
Mental Health Older Persons Ambulatory		4		4		5
Mental Health Older Persons Acute Inpatient		4		4		5

	Level 4		Level 5		Level 6	
Nuclear medicine					4	
Palliative care		4		5		5
Pathology		4	4		5	
Perioperative (relevant sections)	4		5		6	
Rehabilitation		4		5		5
Surgical	3		4		6	

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Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.

Legislation, regulations and legislative standards

Refer to the Fundamentals of the Framework for details.

Non-mandatory standards, guidelines, benchmarks, policies and frameworks

(not exhaustive & hyperlinks current at date of release of CSCF v3.2)

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- Care of Older People in Hospital Standards. Healthcare Improvement Scotland 2015. www.healthcareimprovementscotland.org

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