

Preparing for discharge:

Weekend or day passes are part of the program whenever possible. Passes should be planned well in advance to ensure that your care needs can be met. You and your family will be asked to complete a questionnaire to let us know how your weekend went.

Prior to your planned discharge, the team will review your progress with you and make recommendations. If discharge to home is not possible, alternate living arrangements will be discussed with you and your family.

If you are eligible, community services may be arranged before your discharge. These services may include in-home visits by a personal support worker, nurse, physiotherapist, occupational therapist or other professionals. You may also be eligible for outpatient therapy or the Day Hospital program.

Your discharge will be determined by your abilities, safety and independence.

Providence Care is funded by the Ministry of Health and Long-Term Care and there is no charge for Specialized Geriatric services.

Affix label or card here

Specialized Geriatrics
Geriatric Inpatient Unit

Contact

Specialized Geriatrics
Geriatric Inpatient Unit
St. Mary's of the Lake Hospital site
Providence Care
340 Union St.
P.O. Box 3600
Kingston, ON K7L 5A2

Prior to Admission:
Tel: 613-544-7767
Toll free: 1-800-214-5848

After Admission:
Tel: 613-548-7222 Ext. 2211 or 2212
After 9:00 p.m.: 613-544-5221

Providence
Care

www.providencecare.ca

Specialized Geriatrics* Geriatric Inpatient Unit



*Comprehensive geriatric
inpatient assessment and
short-term rehabilitation*

Providence
St. Mary's of the
Lake Hospital site
Care

*Affiliated with the Regional Geriatric
Programs of Ontario
and Queen's University, Kingston

What is the Geriatric Inpatient Unit?

The Geriatric Inpatient Unit is a hospital program for seniors with multiple health problems who will benefit from a health care team approach to inpatient assessment/review, treatment and rehabilitation.

What is its purpose?

The purpose of the Geriatric Inpatient Unit is to help you become as independent as you can in your mobility and self-care after your operation, illness, accident or gradual decline in your health. This is so that you can return as safely as possible to your place of residence.

Your length of stay is variable (2-6 weeks), depending on your individual needs and rehabilitation progress.

Who may benefit:

- ◆ Aged 65 years and older with complex health issues
- ◆ Recent decline in managing day-to-day activities
- ◆ Difficulty with getting around
- ◆ Recent falls or fear of falling
- ◆ Concerns about medications
- ◆ Recent changes in ability to cope
- ◆ Recent changes to social supports and/or caregiver stress
- ◆ Multiple admissions to hospital or visits to the emergency department or family physician
- ◆ Mood/memory/thinking changes as part of other health change
- ◆ Recent and unexplained changes in health status

Items to bring to the Inpatient Unit:

Make sure all items are labelled with your name.

- ◆ All of your medications from home (prescription, non-prescription, herbal, vitamins, all over-the-counter products)
- ◆ Hearing aids and replacement batteries, glasses, dentures
- ◆ Several changes of comfortable clothing – easy to put on and take off, including socks and underwear
- ◆ Good supportive shoes and slippers that fit (low heeled, non-slip soles only)
- ◆ Unscented toiletry items (Kleenex, comb/brush, toothbrush/paste, deodorant, lotions, shampoo, & electric razor) as these are not provided (some of these items can be purchased in our Gift Shop)
- ◆ Any personal equipment that you were using prior to your admission (such as personal wheelchair, walker, cane, compression stockings, hip protectors, CPAP, incontinence supplies)
- ◆ Immunization record and health card

REMINDER:

Be advised that the hospital does not provide telephones or televisions in patient rooms. On your arrival you can ask about how to arrange for these and other services.

DO NOT bring valuables or large sums of money.

Treatment:

Treatment involves a team approach in which a number of health care professionals work with YOU to customize your care plan.

The care team usually includes nurses, physicians who specialize in geriatric medicine, physiotherapist, occupational therapist, speech-language pathologist, psychologist, registered dietitian, social worker, spiritual care worker, pharmacist, recreation therapist, discharge planner, and a case manager from Community Care Access Centre. We are also a teaching facility and may have health care students assisting in assessment and treatment.

Progress is achieved through daily participation in therapy. For most patients, this could involve a total of two to three hours per day of structured time with various clinicians, as mentioned above.

With your permission, family members are encouraged to be actively involved in your care planning and recovery. They are welcomed and encouraged to attend therapies, and to provide support in applying what you have learned.

You may have a family conference for the purpose of sharing information during the course of your stay.