### Team Composition
Rapid Response for discharge support and prevention of admission with access to care at home to support patients, carers and professional staff. Domiciliary physiotherapy. Mental health for older adults including:
- Access to: Memory clinic
- EMI Day hospital
- Out patient consultant
- Community psychiatric nurses and community rehabilitation
- Social Workers and support workers
Community Physical Disabilities Services
Community Speech and Language therapy
The team also includes dietetics, podiatry, interface pharmacy and specialist nurses (Gerontology, Respiratory and Intensive Care Managers).

### Target Population
People over 16 for non mental health over 65 years for all mental health referrals.

### Referral Criteria
- Medically fit for discharge from hospital and being discharged early where rehabilitation is required to improve their level of function.
- To support patients home from A/E avoiding the need for unnecessary admissions.
- Crisis intervention.
- Patients who require rapid intervention to prevent hospital admission in the community including those in care homes.
- Patients with severe and enduring mental health problems.
- Patients with chronic disease where functional assessment and treatment would improve their level of independence.

### Exclusion Criteria
- Patients with no potential for rehabilitation (excluding mental health).
- Patients who have declined the service.
- Where no needs are identified.
- Patients who are medically unfit for rehabilitation/care in community.

### Who can refer
Any professional working in the community.
Self referrals are accepted to the service excluding mental health referrals.
General Practitioners.

### Response standards
- A/E screened and assessed within 1 Hour.
- GP Rapid Response screened/assessed within 4 hours.
- Mental health urgent patients seen within 3 working days.
- All others treated as routine.

### Screening process
Patient is screened in A/E, in wards, or at home by an appropriate professional member of staff using Standardised Shareable Assessment tool.

### Intervention
Patients are followed up by the appropriate AHP/Nurse/professional with plan for rehabilitation/ongoing care and treatment.

### Discharge
Patients are discharged after regaining an increased level of independence where possible or referred on to an appropriate team/service for ongoing support.
GP will be notified by letter of the outcomes.

### Hours of service provided
The service is available 24 hours via the SPOA phone number.
Urgent referrals seen by RES team.
08.30 – 1900 Monday to Friday.
0900 – 1700 Saturday, Sunday and Public Holidays.
After these hours Renfrewshire Out of hours district nursing service will provide service/advice to referrers, patients and carers.

### Contacts
- Paisley Team Lead – Margaret Irvine 0141 842 411
- Renfrew Team Lead – Emma Cummings 0141 314 4660