Central Adelaide Local Health Network
Central Adelaide Rehabilitation Service

General Rehabilitation
Sub-Acute Model of Care

November 2016
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<tr>
<td>ABI</td>
<td>Acquired Brain Injury</td>
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<td>BI</td>
<td>Brain Injury</td>
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<td>BIRU</td>
<td>Brain Injury Rehabilitation Unit</td>
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<td>CALHN</td>
<td>Central Adelaide Local Health Network</td>
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<td>CARS</td>
<td>Central Adelaide Rehabilitation Service</td>
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<td>DRS</td>
<td>Day Rehabilitation Service</td>
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<td>HRC</td>
<td>Hampstead Rehabilitation Centre</td>
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<td>IDT</td>
<td>Interdisciplinary Team</td>
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<td>LHN</td>
<td>Local Health Network</td>
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<td>MDT</td>
<td>Multi-Disciplinary Team</td>
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<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
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<td>nRAH</td>
<td>New Royal Adelaide Hospital</td>
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<td>NTRU</td>
<td>Neurotrauma Rehabilitation Unit</td>
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<tr>
<td>OWI</td>
<td>Organisation Wide Instruction</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>RAH</td>
<td>Royal Adelaide Hospital</td>
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<td>RiTH</td>
<td>Rehabilitation In The Home</td>
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<td>SABIRS</td>
<td>South Australia Brain Injury Rehabilitation Service</td>
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<td>SASCIS</td>
<td>South Australia Spinal Cord Injury Service</td>
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<tr>
<td>SCI</td>
<td>Spinal Cord Injury</td>
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<tr>
<td>SDM</td>
<td>Substitute Decision Maker</td>
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<td>THIC</td>
<td>Transforming Health Implementation Committee</td>
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<td>TQEIH</td>
<td>The Queen Elizabeth Hospital</td>
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1. Purpose of Document

This document outlines a model of care (MOC) for General Rehabilitation Services initially at Hampstead Rehabilitation Centre and following transfer, at The Queen Elizabeth Hospital (TQEH), Central Adelaide Local Health Network (CALHN).

The MOC describes the objectives, governance and overarching principles of care, the patient cohort, MOC, and enablers.

This plan specifically provides details regarding:

- Service description, profile and service delivery model including operational performance targets
- Patient flows
- Workforce requirements
- Clinical and non-clinical support services

This document describes a rehabilitation service that is aligned to the strategic priorities and goals of the Government of South Australia’s Transforming Health project and to be a sustainable health service that is:

- Person and Family Centred
- Safe
- Effective
- Accessible
- Efficient
- Equitable

As part of the Single Service Multiple Sites model, this MOC also takes into account the integration of services within and across clinical areas of CALHN whereby patients and Substitute Decision Makers (SDM) are supported to receive prompt, appropriate assessment and care.

The MOC underpins the way we provide services across all of our campuses and focusses on our commitment to care and provision of person and family centred care. The diagram below (Diagram 1) summarises the operation of our MOC from a patient pathway perspective across the continuum of care incorporating out of hospital and in-hospital services.

In developing this Proposed MOC for General Rehabilitation other documents relating to aligned services were considered, namely:

- Spinal Cord Injury and Brain Injury Clinical Service Plans and Models of Care for the TQEH
- Draft Ambulatory Rehabilitation Services – Proposed Model of Care
• Draft MOC for the Neurotrauma Rehabilitation Unit at nRAH
• Transforming Health MCAG Rehabilitation Services Development Project:
  Service Components for Optimum Rehabilitation Care in South Australia REPORT
  February 2016

This document is consistent with and aligned in its content to support new models of care being developed for inpatient rehabilitation and Ambulatory Rehabilitation Services. Transforming Health outlines the need for expanded ambulatory services to allow rehabilitation to occur early in the patient journey and where possible in a patient’s home, stating ‘Care should be delivered in the most appropriate cost effective venue as close to home as safely possible’ Delivering Transforming Health – Our Next Steps 1.

It is imperative that all philosophies, processes and implementation plans are aligned in order to develop a self-supporting and sustainable system for rehabilitation.

Diagram 1: SA Health Continuum of Care

Consistent with this, our commitment is that we will improve the care we deliver to our patients by taking a holistic and comprehensive approach. This approach will address direct and indirect services, our workforce and culture improving the care we deliver to our patients in four significant ways:
1.1 Assumptions

The development and ongoing use of this MOC is based on a number of assumptions:

- The MOC document is a point in time document and as such is intended to be a living document that will be revisited and updated along the Transforming Health journey and further evaluated post implementation.
- This MOC has been developed based on the current service targets that have been defined for Central Adelaide Rehabilitation Service (CARS).
- Ongoing transformational processes that are underway across the Local Health Network (LHN) may influence future service locations and operations.
- While these assumptions are important to acknowledge, they do not override or compromise our overarching MOC principles and our commitment to the Transforming Health journey.
- For the purposes of consistency in this document the term 'patient' is used whilst recognising that individuals accessing ambulatory and other community based services are generally referred to as 'clients'.
2. General Rehabilitation

CARS is recognised as a centre of excellence with national and international reputation in the provision of specialist rehabilitation, teaching, research and clinical services.

CARS provides specialised rehabilitation services across the entire health care continuum including rehabilitation for inpatients, outpatients, ambulatory care services and programs, including Day Rehabilitation Service (DRS) and Rehabilitation In The Home (RITH), as set out in the SA Health Care Plan 2007-2016, State-wide Rehabilitation Service Plan 2009-2016 and the SA Health Model of Care for Major Hospitals (2013).

The State-wide Burns Rehabilitation Service is integrated within the general rehabilitation wards and is therefore included in this document. The models of care for the other state-wide services (SA Spinal Cord Injury Service and SA Brain Injury Rehabilitation Service) are addressed in the MOC documents named above.

CARS provides leadership and expertise in the provision of patient-centred, quality and evidence based rehabilitation programs which include stroke and neurological, amputee, orthopaedic, burns and general reconditioning programs. In line with Transforming Health rehabilitation is evidence based and best practice is guided by:

- Clinical Guidelines for Stroke Management (National Stroke Foundation 2010)
- Pathway for Stroke Rehabilitation (SA Health, 2014)
- Model of Amputee Rehabilitation in SA (SA Health, Feb 2012)
- Model of Care for Orthopaedic Rehabilitation (SA Health, May 2011)
- Joanna Briggs Institute (JBI) Burns Node recommended Practices.
- American Burns Association Verification Guidelines 2014
- Australian and New Zealand Burns Association (ANZBA) Allied Health Clinical Guidelines (October 2014)
- Model of Rehabilitation for Spinal Cord Injury in South Australia, Feb 2012
- Model of Rehabilitation for Acquired Brain Injury in South Australia, 2012
- Model of Rehabilitation for South Australia, Feb 2012
Rehabilitation is a component of all medical and surgical care; however certain levels of impairment mandate specialist rehabilitation care. In certain conditions, for example Stroke, Amputation, Multi-Trauma, Burns and in certain individual medical, surgical and geriatric cases, specialist rehabilitation care should proceed in partnership with acute care.

It is expected that the commencement of rehabilitation in acute settings features in the Clinical Service Profiles of these acute services. The patient is appropriate for transfer to CARS once they are medically stable and are willing and able to undertake a minimum of 3 hours of therapy per day. The patient journey is seamless, with open communication of assessment, goal setting and rehabilitation care planning through shared documentation and timely clinical handover.

CARS works in close collaboration with other directorates across CAHLN to ensure early identification of patients requiring rehabilitation assessment and consultation services. Patients identified by clinicians as being appropriate for rehabilitation are referred to the CARS patient flow coordinator who provides a single point of access. The coordinator arranges the appropriate triage, and the CARS multidisciplinary triage team assesses and provides consultancy and, where appropriate, facilitates transfer to rehabilitation services. Close links are maintained with the CALHN Hospitals to ensure safe, efficient and effective transition of suitable patients to general rehabilitation in-patient services and/or to ambulatory or outpatient rehabilitation programs/clinics/services.

Rehabilitation consultants will provide a consultation service and certain procedural services in both inpatient and outpatient settings and are responsible for the clinical management of individual patients within CARS.

### 2.1 Objectives

The objectives of providing General Rehabilitation at TQEH are as follows.

- Improve patient care, by:
  - Streamlining care and developing best practice protocols and pathways across care settings
  - Supporting early detection and prevention of complications that might adversely impact rehabilitation outcomes
  - Providing early assessment and consultation to prevent de-conditioning, maintain and improve function while in the hospital,
thereby potentially reducing length of stay and improving patient outcomes

- Cohorting patients to ensure staff have the appropriate skillsets to manage their complex rehabilitation needs

- Optimise bed management and the patient journey, by:
  - Providing early specialist rehabilitation assessment, management and discharge planning
  - Allowing continued treatment of an acute illness in parallel with the provision of rehabilitation
  - Using ambulatory rehabilitation services optimally to enable early discharge
  - Providing early transfer from an acute bed and reducing total length of stay

2.2 Governance

Patients admitted to inpatient rehabilitation services, including RITH, transfer to a rehabilitation code for case-mix purposes and are managed by the rehabilitation consultant. This case-mix coding enables rehabilitation funding to apply from the time of admission to CARS and a rehabilitation MOC to be provided.

2.3 Principles of Care

The guiding principles of this model are consistent with the State-wide Rehabilitation Service Plan 4 (2009) and SA Health’s aim to optimise care by providing the right care, at the right time, in the right place; consistency and equity in access; seamless services; partnerships in service delivery; and by offering patient and family centred care that optimises physical recovery, function and psychosocial wellbeing, maximises independence, vocation and lifestyle opportunities.

This model operates within a rehabilitation framework. Rehabilitation is “the process of assessment, treatment and management with on-going evaluation by which individuals (and their family/carer/SDM) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living”5.
Rehabilitation services will be tailored to the individual and allow for episodic return (i.e. admission after an intervening time period after discharge from the acute facility) depending upon the nature of the patient’s condition. While the demand for rehabilitation spans all ages, it increases with age. Older people are proportionally the largest group accessing these services. Central to the provision of rehabilitation services is the collaboration between multidisciplinary teams, patients and carers/SDM. This collaboration guides the development and implementation of care plans, and the process of reviewing a patient’s progress against stated goals. Quality rehabilitation activities are patient-focused, educating and enabling patient self-management and taking into account the experiences of patients and those who care for them.

In addition to CALHN values, the general rehabilitation team utilises the following rehabilitation principles in delivering this model:

**Patient-centred care**

- Specialist rehabilitation
  - the total active care of patients with complex disabilities by a multi-professional team which has undergone relevant training in rehabilitation, led/supported by a consultant trained and accredited in rehabilitation medicine
- Multi-disciplinary, team-based care
  - Access for patients to a core specialist rehabilitation Multi-Disciplinary Team (MDT), the members of which work collaboratively
  - Coordinated team-work - a fundamental factor in rehabilitation, along with common goals and a unified plan
- Australasian Faculty of Rehabilitation Medicine (AFRM) Standards
  - Operation of the team in accordance with the AFRM standards for inpatient rehabilitation
- Shared care
  - Direct consultation, shared care, collaboration and partnership between the rehabilitation service and acute teams
- Care coordination
  - The planning, communication and coordination of patient care between the MDT and other care providers across the care continuum
- Evidence-based care
Provision of care in line with the best available evidence

- Continuing Education
  - Knowledge and skills of staff and undergraduate trainees by a commitment to undertake research, professional development and education through appropriate resourcing

CARS also considers overarching evidence supporting strategic documents and will work to scope as described by the Model of Care for Major Hospitals planning principles:

- The State-wide principles developed by the Clinical Senate
- The patient safety design concepts
- Safety and Quality principles incorporating concepts of right care, right time, right place, right person/team

The Model of Care for Major Hospitals aims to support Health System reform so that:

- It encompasses a whole system redesign
- Care is integrated across disciplines, sectors and organisations
- Patients are at the centre of the system
- Evidence informs decisions and practices
- The workforce is supported to become more flexible and involved in shaping the future
- The hospital is a learning organisation and
- Partnerships with other providers, industry, universities and other key stakeholders are actively promoted

3. Model of Care

CARS inpatient rehabilitation programs provide an evidence based, multidisciplinary approach to rehabilitation. CARS recommend that patients with similar diagnoses are cohorted to embed evidence based practice within the treating teams, promote peer support within similar patient groups, improve patient care and maximise efficiencies in collaborative care planning. Cohorting principles in a general rehabilitation setting support person and family centred care by allowing timely access to inpatient rehabilitation and limiting unnecessary moves and delays to a specialist unit. Teams working collaboratively allows for upskilling across the whole workforce.
Rehabilitation programs are underpinned by a strong multidisciplinary service model which follows rehabilitation principles with person and family centred care planning and collaborative goal setting. Core principles of rehabilitation are integrated into clinical practice in reference to the Rehabilitation Generic Core Competencies Framework 7.

CARS develop close working relationships across the range of CALHN services and teams. Patients admitted to rehabilitation programs may benefit from access to the expert consultation services of other specialist teams.

CARS provide a comprehensive consultative service to other specialties and to staff working in regional and rural areas with complex patients requiring rehabilitation. Access to tele-health facilitates case discussion and consultation, and complements research, education and training programs.

Diagram 4 – Underpinning Model of the CARS Patient Journey 8

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3.1 Inpatient

3.1.1 MOC Key Elements

- Patients on the Rehabilitation Unit are co-located with like diagnostic groups wherever possible.
- Patients on the Rehabilitation Unit attend dedicated therapy and dining areas.
- There is a core rehabilitation staff group caring for patients in the Rehabilitation Unit.
- The core rehabilitation staff attend daily progress / journey board meetings, case conferences and family meetings.
- A Rehabilitation Coordinator is assigned and makes initial contact with the patient’s family/SDM within 48 hours of admission.
- A Rehabilitation Consultant Review is completed within 24 hours of admission.
- A MDT assessment is completed within 48 hours of admission (within 24 hours for Burns Rehabilitation and schedule finalised).
- Specific Measurable Achievable Relevant Time-targeted (SMART) goals are established in collaboration with the patient/SDM within 48 hours of admission. Those goals that must be achieved to allow discharge to the community are identified and given priority, within 24 hours for Burns Rehabilitation.
- Patients/SDM are provided with an agreed rehabilitation goal sheet within 72 hours of admission.
- Based on assessments by the MDT and supported by best practice evidence therapy is provided as clinically indicated. A minimum of 2 hours of direct task specific therapy per patient over six days per week is provided with additional opportunities for practice each day to equal a total of 3 hours -as per MCAG Rehabilitation Development Project ‘Service Components for Optimum Rehabilitation Care in South Australia Report’ (3.5 hours for Burns rehabilitation).
- An up to date treatment plan is maintained.
- Goal achievement is reviewed daily at journey board meetings.
- Patients are reviewed by treating members of the MDT Daily.
- Patients are encouraged and facilitated to actively work towards therapeutic and discharge goals 7 days per week.
- Rehabilitation goals and programs are discussed with patient, family and carers/SDM with family meetings scheduled (with consent).
- All staff have responsibility to communicate with the patient, family and carers/SDM on patient progress, program and discharge planning (with consent).
- Carer training is provided before discharge as required.
- A multi-disciplinary electronic discharge summary is completed and sent to the patients GP and management team (with consent) and given to the patient or SDM on discharge.
- The core multi-disciplinary team will comprise: nursing, medical, physiotherapy, occupational therapy, speech pathology, social work and an allied health interdisciplinary professional. Patients will have access to other
therapy disciplines including, but not limited to: clinical psychology, neuropsychology, podiatry, nutrition and dietetics, orthotics / prosthetics, OT Driver Assessors and exercise physiology.

- Inpatients require easy access to appropriate specialist peer support.

### 3.1.2 Specialist Key Elements

#### Stroke Rehabilitation

The SA Stroke Service Plan 2009-2016 recommends patients recovering post stroke should be managed in a dedicated stroke rehabilitation unit with strong links to the Acute Stroke Unit. Continuity of care is recommended from admission to discharge and teams based care is provided based on NSF Guidelines for Stroke Rehabilitation and Recovery, it further advocates for age appropriate rehabilitation services. The National Stroke Guidelines also recommend a dedicated Stroke Liaison / Coordinator role and this concept is supported within this Model of care. Patients who have had a stroke will be managed by a Rehabilitation Consultant or Geriatrician as the need requires. The core multi-disciplinary team for Stroke patients will include psychology (clinical and neuropsychology).

#### Amputee Rehabilitation

Amputees will be managed by a Rehabilitation Consultant-led team. The core multidisciplinary team (nursing, physiotherapy, occupational therapy and social work) will also include an Amputee Coordinator, Prosthetics and Clinical Psychology. Strong links with the Acute Vascular unit will be maintained. Amputees require easy access to Limbs 4 Life (or other) peer support agencies on site.

#### Orthopaedic Rehabilitation

Younger orthopaedic patients, especially those with multi-trauma will be best managed by a Rehabilitation Consultant-led team, while older orthopaedic patients, especially those with age-related frailty, multiple comorbidities and/or cognitive impairment may be best managed by a Geriatrician-led team. Strong links with the Acute Orthopaedic unit will be maintained.
Burns Rehabilitation (Statewide Service)

Burns rehabilitation begins on admission to the acute burns unit, and extends in a continuum. There is a need for in-reach by acute therapists to assist in the management of patients with complex injuries and to avoid deconditioning, contracture formation, loss of function and optimise pain management. In-patient, ambulatory rehabilitation and longer term follow up may be required to ensure optimal outcomes. Collaboration will occur with the inpatient acute Burns Unit prior to the transfer of patient to inpatient rehabilitation as per relevant OWI currently being developed.

Deconditioning Rehabilitation and General/Neurological Rehabilitation

Rapid deconditioning resulting in debility is a recognised serious complication with acute illness, with a cohort of patients requiring the intensity of a multi-disciplinary rehabilitation service. Patients with a diagnosis of Multiple Sclerosis, Parkinson’s Disease, Huntington’s Disease, Guillain-Barre Syndrome and other medical or neurological conditions that are complicated by acute illness may also benefit from a period of in-patient multidisciplinary rehabilitation. The expertise of Geriatricians and Rehabilitation Consultants is required for the care of these patients in conjunction with the other multidisciplinary team members.

3.1.3 Rehabilitation in the Home (RITH)

RITH is a home-based sub-acute rehabilitation service that aims to assist people to achieve their best level of independence through early supported discharge from hospital. The service has additional admission criteria with an aim to:

- Improve the overall function of patients in a non-hospital setting.
- Facilitate of earlier hospital discharge, thereby reducing length of stay in the acute/subacute setting.
- Facilitate smooth and safe discharge from the hospital setting.
- Prevent admission or readmission of patients needing additional rehabilitation therapy.

RITH has the capacity of 20 ‘virtual’ community based beds and provides services to patients who reside within the CALHN catchment area. Rehabilitation services will be tailored to the individual depending upon the nature of the patient’s condition.

3.2 Ambulatory Services
3.2.1 Day Rehabilitation Service (DRS)

The Day Rehabilitation Service (DRS) offers sub-acute, centre based ambulatory rehabilitation services to patients in the community, with the capacity for some home or community based interventions.

DRS provides an interdisciplinary assessment for new patients from the community or acute inpatient services; facilitating the collaborative care planning and goal setting with the patient. Patients from inpatient rehabilitation services, including RITH, are transitioned to DRS in a timely manner without the need for further interdisciplinary assessment.

Rehabilitation programs are delivered on a 1:1 and group basis, including hydrotherapy. The intensity of the rehabilitation program offered is based on assessment of the patient’s needs with a view to offering similar intensity as the referring inpatient rehabilitation service to support the early transition into ambulatory services. Intensity can be increased for the patient with the introduction of telehealth capabilities to the individual rehabilitation program.

3.2.2 Outpatient Clinics

CARS will offer outpatients services to the rehabilitation patient cohort as required. Outpatient clinics provide individuals with the opportunity to access specialist medical and or MDT assessment / review and therapy interventions to improve / maintain their independence and function. These clinics are most suited to individuals that can be managed by either a single or Multi-Disciplinary outpatient service. “Development of outpatient clinics that are interdisciplinary and multidisciplinary including medical, nursing & allied health that focus on specific areas requiring rehabilitation post injury or illness such as driving, swallowing and spasticity is important” 12 . To enable equity and access to these services, outpatient services at various locations across CALHN.

Outpatient Clinics

- Rehabilitation Medicine
- Stroke Review
- Amputee Rehabilitation
- Multi-trauma Rehabilitation
- Spasticity Clinic
- Transition Clinic (paediatric to adult)
Allied Health Profession specific clinics e.g. Physiotherapy, Speech Pathology
Driver Assessment

3.3 Early Rehabilitation

The guiding principles of this model are consistent with the State-wide Rehabilitation Service Plan and SA Health’s aim to optimise care by providing the right care, at the right time, in the right place. The model is also in line with CALHN’s single service, multiple site models which supports early commencement of rehabilitation and seamless transitions across care settings.

Rehabilitation starts in the hospital as soon as possible for patients who are stable, and should be continued as necessary after discharge. Early rehabilitation is important to maximise recovery, prevent de-conditioning, optimize function while in the acute hospital, enable earlier assessment, intervention and discharge planning\(^{13}\). There has been documented correlation between better outcomes for patients and earlier access to rehabilitation\(^{14}\). Under this proposed model, rehabilitation may occur earlier as an adjunct to their acute treatment with patients remaining in or near the acute unit where relevant medical, surgical, critical care and support service expertise is readily available.

The management of patients may be shared with colleagues in acute care and the development of these new relationships and ways of working is critical to the success of this service element.

3.4 Patient Casemix

- Stroke or neurological conditions
- Orthopaedic and musculoskeletal trauma and conditions
- Vascular conditions and amputation
- Post-surgical and medical deconditioning
- Burns

3.5 Admission Criteria

3.5.1 Inpatient

1. Patient agrees to participate in a rehabilitation program with the aim to improve function.
2. Patient is medically stable with a clear plan for further management or investigation and medical/surgical follow up if required.
3. Patient will have sufficient cognitive and physical function to participate in a rehabilitation program.
4. Have mutually agreed therapy goals that can be achieved in the inpatient setting.

3.5.2 Additional Criteria for Rehabilitation In The Home (RITH)

- The patient requires short-term, goal-specific rehabilitation (~2-4 weeks)
- Patient requires light assistance for mobilisation
- Patient has a carer available or sufficient social supports
- The patient has a home suitable for therapy
- Has a telephone/mobile
- GP consents to continue medical care
- Resides within CALHN
- Agrees to readmissions should complications occur
- Have the ability to contribute to weight bearing transfers
- Documentation of special considerations e.g. If the patient’s weight is over 120kgs, then special equipment to provide care will require specific planning

3.5.3 Day Rehabilitation Service

Admission Criteria
- Adult patients
- Residing within CALHN catchment area.
- Have experienced a recent health or medical event resulting in a loss of function and/or independence, including communication deficits.
- Require a multidisciplinary team based approach i.e. require 2+ discipline involvement with only exception being the Speech Pathology Unit which can accept single discipline referrals.
- Have achievable, time appropriate rehabilitation goals.
- Consent to participate in a rehabilitation program.
- Possess both the cognitive and physical capacity to participate in a rehabilitation program.
3.6 Central Point of Referral

The main source of General Rehabilitation referrals are the acute and other subacute inpatients areas of the Royal Adelaide Hospital (RAH) and TQEH. It is acknowledged that referrals come from other sources including but not limited to: other LHN’s, Country Health SA, Metropolitan Private Hospitals, community, interstate and overseas.

Referring units are required to have a discussion with the patient and/or family/SDM regarding the referral, and obtain consent prior to forwarding the referral to the CARS central point of referral – Patient Flow Coordinator.

CARS utilises one referral form for all inpatient services facilitating ease of referral and access to services.

Once received, the Patient Flow Coordinator forwards the referral to Triage team for assessment. All patients referred are seen by Triage team within 24hrs of referral (with the exception of Sundays and public holidays).

See Appendix 1 for Triage Process Pathway

3.7 Triage & Assessment

The Triage and Assessment Team provides comprehensive assessment, and discussion with the ward/unit team and patient/carers/family/SDM to make recommendations regarding the most appropriate rehabilitation service within CALHN that meets the patient’s identified rehabilitation goals and needs. This may include ambulatory services where possible and / or an inpatient sub-acute admission.

Referral patients can also be admitted directly to inpatient rehabilitation units from the community after assessment by the CARS Triage and Assessment Team. This may include readmission from Rehabilitation in The Home (RITH) or ambulatory services within CARS, or from other rehabilitation programs. Geriatricians/Rehabilitation Consultants and Multi-Disciplinary professionals are available to consult as required. Once the patient has been reviewed, the CARS Triage and Assessment Team will inform the referring team of eligibility and acceptance/non-acceptance. If the
patient is not eligible or accepted, CARS Triage and Assessment Team may, where appropriate, make recommendations for alternative assessment by, or referral to other services/agencies.

Once medically stable and following the CARS Triage and Assessment Team’s assessment, patients who are suitable and ready for transfer to CARS will be transferred once the appropriate service has capacity. Referring sources are required to inform the central point of referral if there are any changes in the patients’ medical status that may affect their transfer or their participation in a rehabilitation program.

3.8 Discharge Criteria and Pathways

Multi-Disciplinary Discharge Planning
Efficient multi-disciplinary team work, person and family centred care planning and goal setting processes are implemented and supported by regular multi-disciplinary case conferences where patient’s rehabilitation progress and discharge plan is reviewed with the patient. Discharge planning commences with the CARS consultation, assessment and the multidisciplinary team in collaboration with the patient/family/SDM. The Rehabilitation service will proactively manage, transfer and discharge patients to the most appropriate setting as soon as practical and clinically indicated.

Discussions and decisions on each patient’s predicted length of stay (LOS) occur at case conferences and are determined by the MDT, based primarily on treatment goals and patient needs. The multidisciplinary rehabilitation team utilises daily huddles and journey boards to support the discharge planning process. The predicted LOS is guided by the experience of rehabilitation team members and Health Round Table (HRT) data for acute episodes and the Australasian Rehabilitation Outcome Centre (AROC) for LOS national benchmarking data for subacute episodes.

To ensure effective and streamlined discharge processes, the principles of effective clinical handover are utilised to ensure key community stakeholders are communicated with and provided with timely handover of a patient’s medical and functional status on discharge, including care needs and recommendations for post discharge follow-up.
To ensure efficient discharge planning, it is essential to have timely access to a range of services including: inpatient assessment by the South Australian Aged Care Assessment Team (SAACAT), post discharge community based services/programs, such as TCP, Local Council and Day Therapy centre programs and Department for Communities and Social Inclusion (DCSI) services/programs (including Domiciliary Care programs, Disability SA co-ordination and care hours etc.) and Centre for Physical Activity in Ageing (CPAA). Another significant pathway is to ongoing ambulatory rehabilitation and early supported discharge services with CARS.

CARS will collaborate with key community based stakeholders including GP network, aged care facilities, service providers, and other community agencies/services, ensuring that each patient has safe and coordinated transition back to the community. CARS proposes that appropriate referrals and effective coordination of post discharge services would lead to optimising patient care/management within the community setting leading to reduction in hospital readmissions/presentations.

CARS recognises that service gaps exist within the community sector such as care needs, home modifications, equipment provision and accommodation. When patient care needs are unable to be adequately met by any community service/program, CARS will escalate service gaps/issues directly to the applicable Directorate. CARS also recognises that individuals face difficulties in the transition from paediatric to adult rehabilitation services and advocates for service provision to facilitate this transition.

- Discharge / transfer from CALHN acute beds is coordinated by the Rehabilitation triage team, and guided by individual needs and service admission criteria.
- The Rehabilitation service proactively manages and transfers patients to the most appropriate setting, facilitating discharge from the acute setting as soon as practical and clinically indicated.
- Rehabilitation goals and individually prescribed equipment (e.g. specialised wheelchairs) follow the patient during their journey (to avoid duplication), where applicable.
- Patient pathways are fluid and vary according to individual needs.

Transition Units with CALHN
Transition Care Beds (e.g. St Margaret’s Hospital) are critical for patients who:

- are deemed eligible for rehabilitation but are not yet ready for active rehabilitation,
- or have completed their inpatient rehabilitation but are unable to return to the community as they are non-weight bearing or require extra time for wound healing, or are awaiting accommodation or equipment, permanent placement in residential care facility, care services or funding.

It is crucial that if patients are admitted to transition beds awaiting rehabilitation, that their progress is monitored by CARS to ensure they remain appropriate for rehabilitation and have timely access into rehabilitation programs. If patients are discharged from rehabilitation into transition beds, appropriately skilled staff are also required to facilitate the patient’s discharge back into the community.

Care Awaiting Placement

Care Awaiting Placement beds (e.g. St Margaret’s Hospital) across CALHN provide care for patients who are awaiting placement, however limited allied health input is available. The Transforming Health Rehabilitation Service Project is recommending a SA Recovery Unit be established that will accommodate two distinct groups of patients.

- Those who have completed their rehabilitation program but still require access to skilled nursing and therapies to maintain their functional recovery level whilst waiting for accommodation and equipment. There may be a need for maintenance therapy to maintain the client at the achieved level.
- Those that require a less intense level of therapy than provided in inpatient rehabilitation setting (3 hours per day for 6 days a week) and where the final functional recovery level has not been reached but they are unable to return home and receive their program from an ambulatory team.

Discharge destinations include but are not limited to:

- Discharge to home with appropriate community services support, in collaboration with the general practitioner (GP) and with access to on-going ambulatory and outpatient services as required
- Discharge to Supported accommodation in the community
- Discharge to Residential aged care facility
**NB** State-wide services e.g. Burns, will continue to follow patients for lifetime of the patient to ensure chronic health issues related to burns injury are managed by in collaboration with the general practitioner and community supports in an effort to avoid readmission to inpatient facilities.

See Appendix 2 for Patient Pathways Flowchart

4. **Enablers**

4.1 **Workforce**

This MOC will be underpinned with comprehensive clinical support services incorporating the full scope of health professionals to provide clinical care, clinical assessment and consultation, therapy, diagnostic, interventional and procedural work. This may include new or expanded clinical roles and clinical support roles.

Across CARS services, there should be sufficient access to nursing and allied health staff with experience and skills in rehabilitation, including access to a 7 day allied health service. This will maximise patient outcomes, prevent potential deconditioning and ensure that patients are receiving the appropriate dosage of rehabilitation to ensure maximum recovery with transition to the community as soon as is appropriate. This practice has the considerable potential to impact on reducing the patient’s length of stay within inpatient rehabilitation programs.

- This model requires a dedicated, specialist multi-disciplinary team, which includes an allied health interdisciplinary professional, sufficient for bed base, at optimal intensity of input, enhanced to enable services across 7 days (with hours matched to needs and the early rehabilitation objectives) and to meet the demands of in-reach consultancy across CALHN.

- Clinical Workforce requirements includes:
  o Rehabilitation Consultants, supported by trainee medical officers, including 24hr cover.
  o Specialist rehabilitation nursing, including 24hr cover (sufficient to reinforce therapy programs, and flexibility to cater for patients with high dependency nursing).
Allied health staff including: physiotherapy, occupational therapy, clinical dietetics and speech pathology, podiatry, orthotics and prosthetics, exercise physiologists, social work, clinical psychology, neuropsychology, equipment and seating technicians, therapy assistants.

The Australasian Faculty of Rehabilitation Medicine (AFRM) standards for inpatient adult rehabilitation services should be applied to determine workforce requirements.

The AFRM guided core workforce levels will need to be further enhanced to deliver:

- therapy programs after hours and on weekends
- responsive and effective shared care and in-reach across the CALHN
- adequate cover of leave and non-patient attributable time (including research, training and education, and professional development)
- enhanced essential services, i.e. seating technicians, to enable earlier equipment provision

• To retain and build appropriate skill sets the clinicians will work across the service elements of early acute rehabilitation, sub-acute rehabilitation and ambulatory services.

4.2 Optimised Rehabilitation across the Continuum

This model does not work in isolation, but should be considered within the context of the CALHN service elements, and other interdependencies.

In line with the single service, multiple site models and in consideration of the holistic needs of patients, there will be a range of rehabilitation services across the continuum to be able to provide the right care in the right place at the right time.

It is essential that appropriate specialist ambulatory services exist to provide a continuation of care following the inpatient episode, facilitating early discharge and avoiding unnecessary transfers and re-admissions. This is particularly required in order to support the efficiencies required to support a reduction in the total number of CARS inpatient beds.

Working as a single service across multiple sites will require access to timely transport and storage for equipment items to move between the acute, sub-acute and storage sites, access to all other speciality services within CALHN and administrative...
data collection support. Appropriate levels of equipment and seating technician workforce will be required to facilitate this.

4.3 Infrastructure and Equipment

The infrastructure requirements of high quality, effective and efficient Rehabilitation services are substantial. Elements include therapy space, consultation rooms, sufficient office (blue) space, equipment storage, outdoor patient areas and information technology.

It is important that members of the multidisciplinary team spend as little time as possible in travel between the ward, therapy space, consultation rooms and office (blue) space and other sites, particularly for smaller speciality workforces such as seating and wheelchair technicians. It is therefore critical not only that the floor space dedicated to these elements be adequate, but also that they be located as close as possible to the ward and to each other.

Therapy space supports assessment and active therapy in both individual and group modes. It is by its nature demanding of substantial floor space, and should be able to accommodate: large items of equipment (e.g. treadmills, body-support gait equipment and other exercise equipment, parallel bars, lifters; and functional areas (e.g. kitchen, bathroom, and toilet). Space should be adequate for the storage of a large amount of equipment and therapy aids.

Wheelchair and Seating is also an essential component of rehabilitation, particularly for patients who are non-ambulant. An appropriate wheelchair workshop that will enable minor wheelchair and seating modifications and adjustments in a timely manner is required so that patients can undertake their rehabilitation programs. There also needs to be easy access to a hydrotherapy pool, outdoor mobility setting and a car for transfer practice. These facilities are integral to therapy.

Private consultation rooms for individual sessions such as psychological therapy, cognitive assessment and retraining that are quiet, private and non-distractible are also required. Private and sound proofed consultation rooms must be on or close to the ward in order to facilitate ad-hoc patient/family visits.

A designated Driver Assessment and Rehabilitation room, with a plinth and space to undertake standardised assessments is also required.

Blue space is where much of the work to support direct clinical care takes place. It should be adequate in dimension to accommodate the full multidisciplinary team.
To implement this MOC the hospital will rely on information technology to support communication at all levels, management of clinical information, access to clinical protocols, order entry, clinical decision making support, bed management and patient tracking systems are all required. Technology can also be used in therapy, e.g. telehealth with the addition of treatment applications on tablets and smartphones, which can be used in the community by the home rehabilitation or day rehabilitation team.

Videoconferencing via telehealth with community service or rehabilitation providers to whom the patient’s care has been transferred to also supports early supported discharge and hospital avoidance strategies.

A healing environment is desirable for patients and providers and includes external spaces. Well-designed physical settings play an important role in the healing process of patients in health care facilities. The environment needs to also be considered in the implementation of this model of care.

Inpatient
- Access to joint therapy area on the ward
- Storage space (on or off site) for equipment items that cannot be stored in the therapy space
- Equipment workshop
- Therapy and ward equipment for rehabilitation (see appendix 2 for indicative list of therapy items)
- Access to private meeting room(s) suitable for individual assessment and treatment sessions, counselling, and family meetings. A networked PC with nearby printer access is required in meeting rooms to support patient clinical sessions with access to information and resources
- Review potential to utilise existing spaces for communal dining for patients, under nursing supervision
- Access to tele-rehabilitation facilities to support transitions to regional services.
- Accommodation for rehabilitation staff in staff working areas
- Access to area(s) for practicing mobility (steps, ramps etc.)

Rehabilitation Centre

Transport:
- Fleet cars

Treatment Space Requirements:
• OT - ADL Kitchen
• OT Functional treatment spaces for individual / group activities e.g. UL group
• OT cognitive assessment and treatment rooms
• OT Driver Assessment and Treatment Room with plinth and space to enable standardised testing
• Speech pathology treatment areas
• Psychology, Dietetics and Social work counselling spaces
• Doctor consults rooms
• Group Room
• Disabled access toilets
• Disabled and other client parking
• PT / EP Gym: Fully kitted gym with parallel bars, walking aids, lifters, gait aids, therapy equipment (hand & leg weights, balance balls, mats), plinths, mobile mirrors, treadmills, exercise bikes, transfer boards, wheelchairs, balance boards, assessment steps
• Outdoor area to assess outdoor mobility
• Exercise physiology equipment: treadmills, recumbent bikes, resistance weight machines (pulley system, leg press), arm ergometer, pulse oximetry, ECG, Shuttle
• Access to Hydrotherapy (may be still through HRC pool)

Offices and Shared Spaces:

• Shared office space for team and manager + office equipment. NB: nRAH blue space principles to be applied
• IT equipment
• Admin area
• Team meeting room
• Staff lunch area
• Staff Parking

Stores:

• Equipment storage for therapy equipment and consumables
• Secure Clinical notes storage
• Stationary / admin storage area
• Access to Equipment Loan pool e.g. TREP
5. Appendices

5.1 Appendix 1 – Triage Process Pathway

ALL REFERRALS SENT TO CARS PATIENT FLOW COORDINATOR VIA EMAIL OR FAX

REFERRAL ALLOCATED TO TRIAGE TEAM MEMBER FOR ASSESSMENT AND REVIEW WITHIN 24 HOURS

TRIAGE DISCUSS REHABILITATION OPTIONS AND POTENTIAL GOALS WITH PATIENT +/- FAMILY. REVIEW MEDICAL RECORD AND LIAISE WITH HOME TEAM. COMPLETE FORMAL ASSESSMENT, MAY IN ADDITION REQUEST ANOTHER DISCIPLINE REVIEW e.g. REHABILITATION CONSULTANT FOR COMPLEX PRESENTATIONS OR OT FOR SPECIALIST EQUIPMENT REQUIRED

OUTCOME OF TRIAGE ASSESSMENT IS DOCUMENTED IN MEDICAL RECORD AND COMMUNICATED TO REFERRAL SOURCE AND PATIENT / FAMILY, RECORDED IN DATABASE TO ENABLE ACCESS FOR PATIENT FLOW COORDINATOR AND TRIAGE TEAM, KPI REPORTING. IF UNSUITABLE FOR INPATIENT REHABILITATION - ALTERNATE PATHWAYS ADVISED.

SUITABLE BUT MEDICALLY UNSTABLE, FURTHER ONGOING REVIEWS BY TRIAGE TEAM UNTIL READY FOR REHABILITATION

SUITABLE AND READY FOR REHABILITATION PLACED ON CARS WAITING LIST AND PATIENT FLOW COORDINATOR NEGOTIATES ACCESS
### 5.2 Appendix 2 - Patient Pathways

<table>
<thead>
<tr>
<th>CARS Central Point of Referral Assessment &amp; Triage</th>
<th>Eligibility, Awaiting programs</th>
<th>Rehabilitation services</th>
<th>CARS Rehabilitation programs</th>
<th>Rehabilitation process</th>
<th>Follow-up &amp; Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral from CALHN medical or surgical units - Major or General Hospital</td>
<td>Assessed as eligible but not medically ready for rehabilitation. Regular review &amp; monitoring by CARS Triage &amp; Assessment team</td>
<td>Referral to In-Reach team for assessment management &amp; early rehabilitation</td>
<td>Stroke/Complex Neurological</td>
<td>Comprehensive Multi-D assessment in partnership with patient and family. Goals for discharge determined (Multi-D &amp; patient centred). Rehabilitation plan developed</td>
<td>Referral &amp; acceptance to discharge/transfer to CARS Transition Beds e.g.: Rehabilitation program completed; awaiting services, care funding or specialised equipment with goal of return home. Awaiting appropriate accommodation. Assessed as requiring residential care - awaiting placement</td>
</tr>
<tr>
<td>Ambulatory services e.g.: RITH, Day Rehabilitation Services, OPD Review &amp; for follow-up clinics</td>
<td>Eligible &amp; ready for transfer to Rehabilitation</td>
<td>In-patient Rehabilitation programs</td>
<td>Orthopaedic &amp; Multi-Trauma</td>
<td>Rehabilitation plan developed</td>
<td>Referral &amp; transfer of care to CARS Ambulatory Care services</td>
</tr>
<tr>
<td>Community service or agency e.g. GP, TCP, ACAT, Aged care services</td>
<td>CALHN Transition Beds</td>
<td>Ambulatory Rehabilitation e.g.: RITH, Day Rehabilitation, OPD review &amp;/or</td>
<td>Amputee</td>
<td>Individualised therapy &amp; retraining programs</td>
<td>Rehabilitation in the Home (RITH)</td>
</tr>
<tr>
<td>Metropolitan Private hospitals; County Health SA; other Local Health Networks</td>
<td>Assessed &amp; Appropriate for Rehabilitation; Not ready for active program e.g.: NWS, amputee wound healing</td>
<td>Transfer to another LHIn service/program</td>
<td>Burns (State-wide Service)</td>
<td>Daily evaluation of progress</td>
<td>Day rehabilitation service</td>
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<tr>
<td>Patient further provides informed consent, patient prioritised for admission</td>
<td>Transfer to County Health service/program with support of Outreach &amp; Telehealth services</td>
<td>Reconditioning</td>
<td></td>
<td>Collaborative discharge planning</td>
<td>CFP review &amp;/or follow-up clinics</td>
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<tr>
<td></td>
<td>Ineligible or inappropriate for rehab</td>
<td>Recommendation on alternative care options and/or pathways</td>
<td></td>
<td>Coordination of Referrals short-term &amp; long term supports/services</td>
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<td></td>
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<td>Clinical Handover Discharge</td>
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<td></td>
<td>Access to specialist assessment &amp; in-reach services from acute</td>
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<td>Readmission to acute setting if requiring acute medical management</td>
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</tr>
</tbody>
</table>

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Discharge from CARS Rehabilitation services: transfer of care to community services & GP.
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