STATEWIDE REHABILITATION TRIAGE / REFERRAL

As part of the Transforming Health Rehabilitation Services Development Project, the following principles were agreed following a statewide stakeholder workshop in March 2017. The Implementation Oversight Committee subsequently endorsed these at their May 2017 meeting, to be adopted across each Local Health Network (LHN).

Principles

Single statewide assessment

In general rehabilitation services in SA, an assessment of the suitability for rehabilitation services done by appropriate staff at one hospital (service) will be accepted/used by another hospital (service).

Referral Forms

It is not imperative to use the same form, however LHNs need to ensure all current documentation covers the same core domains and as such can be accepted by all services.

Admission to a General Rehabilitation service

A General Rehabilitation service will only accept patients who are likely to achieve functional gain. When a patient is assessed and refused access to a rehabilitation bed or service, a senior clinician/decision maker from the rehabilitation service needs to be the point of contact, and explain the reasons to the family and provide explanation as to what needs to occur/what changes to look out for that would indicate to the family that the situation has changed. Justification also needs to be communicated to the acute service. A contact number shall be provided.

Patient centred care

Working cross-LHN is desirable. When an LHN reaches capacity, and there is a potential for long waits for service provision, working with other LHNs to offer a service out of the LHN is an agreed strategy, recognising the need to seek patient consent and the need to meet LHN demands.

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Care Setting

The default care setting should be ambulatory, with justification provided for why an inpatient rehabilitation setting is required or being recommended.

Triage

A coordinated approach to the triaging of patients will be adopted, and enabled through use of CART (Communication Auditing Reporting Tool).

Ready for Rehabilitation Criteria

The following is a good practice guide to a person who is ready for discharge to a rehabilitation program:

- Patient is medically stable and able to participate in the rehabilitation program in the chosen care setting (see below for detail about care settings)
- Patient has been assessed by an appropriate professional (eg rehabilitation physician, rehabilitation coordinator or other) as requiring rehabilitation in the chosen care setting/ environment (based on their physical/ medical/ functional, cognitive, psychosocial, social needs).
- There are clear, achievable rehabilitation goals documented and agreed.
- Patient is likely to make functional gains. In general, no admission will be made to the rehabilitation service if there is likely to be no functional gain.
- Discharge destination has been discussed with patient/carer and agreed or the team is working towards a discharge destination.
- Patient and/or carer consents and is able to participate in the rehabilitation process, including the intensity of therapy provided, in that care setting (i.e. motivation/ active patient participation). Patient and/or carer rehabilitation needs are aligned to service delivery available in the care setting.
- Special needs are able to be met in that care setting (eg non weight bearing patients).
- Clear and accurate documentation of ongoing management plan and necessary follow-up.
- Patient falls within the care setting case mix classifications agreed/able to be accommodated in that care setting.
- There is consideration of a trial of rehabilitation to determine a patient's ability to participate and potential to benefit from the program.

When considering readiness for rehabilitation the care setting is discussed. SA considers that people should be referred to the setting which matches their care needs. Settings in the community are considered first with inpatient settings considered for those people with the highest care needs.

The first preference for a rehabilitation setting is in the community.

Care Setting – Admission Criteria

Day Rehabilitation

- Rehabilitation goals can be met within a time limited program
- Can return safely to home and has a safe home environment (including for staff)
- Carer and patient consent
- Carer willing to be involved in program
- Is able to access an outpatient rehabilitation program (including transport)
- Does not require contextualised rehabilitation within the home environment
- Able to tolerate intensive rehabilitation
- Has endurance to attend multiple sessions across a day
- Medical considerations can be managed at home
- Have a telephone or other communication device and plan in place for seeking assistance
- Require multiple disciplines

Home Rehabilitation

Meets criteria for Day Rehabilitation BUT requires contextualised rehabilitation – ie needs to be in the home environment to understand rehabilitation re-training, which cannot be replicated in a day rehabilitation setting.

IF PATIENT IS NOT ABLE TO RETURN HOME SAFELY (FOR MEDICAL OR OTHER REASONS) then inpatient rehabilitation in either a collocated ward in a general hospital or a stand alone rehabilitation facility will be required.

Inpatient (co-located with tertiary/ general hospital)

- Patient is unable to go home safely
- Patient requires intensive period of rehabilitation to achieve goals/ or facilitate discharge to next stage
- Ability to tolerate intensive rehabilitation (minimum of 2 hours per day therapy)
- Medically stable

Inpatient (provided in a non-acute setting, not co-located with tertiary/general hospital)

- Patient can be safely managed with limited medical cover that is available 24 hours (may be on-call remotely or onsite depending on Model of Care available)
- Low risk of transfer to tertiary hospital. Clear protocols and processes for up transfer to tertiary hospital if medically required.
- Urgent medical investigations completed by acute hospital prior to transfer