St Vincent's Hospital
Clinical Procedure

SVH Rehabilitation in The Home Referral and Service Criteria Procedure

Links to Policy	Clinical Core Policy
Applicable:	Rehabilitation Clinical Staff Rehabilitation in The Home Team
Classification:	Operational
Date Introduced:	
Date Approved:	
Approved by:	
Revision No.:	
Last Review Date:	
Scheduled Review Date:	
Responsible for Review:	RITH Steering Committee
Key Words:	Rehabilitation, RITH

Objective:

The Rehabilitation in The Home Team (RITH) is a new initiative for patients in the acute and sub-acute areas of St. Vincent's Hospital (SVH), Sacred Heart Rehabilitation Service (SHRS) and Prince of Wales Hospital (POWH). It is a Monday to Friday home based multidisciplinary rehabilitation intervention for patients who do not require hospitalisation. The RITH process will be one in which the Rehabilitation team assesses and manages the client in their own home.

The aims of RITH are:
1. To improve the overall function of patients in a non-hospital setting.
2. Facilitation of earlier hospital discharge, thereby reducing length of stay in the acute/subacute setting.
3. To facilitate smooth and safe discharge from the hospital setting.
4. Prevent admission or readmission of patients needing additional rehabilitation therapy.

Principles of Action:

- Patient Assessment and Referral
- Discharge planning
- Length of stay and patient flow
- Hospital admission avoidance

Definitions:

RITH Rehabilitation in The Home

1. Roles and Responsibilities:

1.1. Scope:

This procedure applies to all clinical Rehabilitation staff involved in the assessment and referral of patients for entry into the RITH program.

1.2. Responsibilities

- Rehabilitation Clinicians are responsible for assessing appropriateness for RITH, and referring appropriate patients to RITH
- The RITH coordinator is responsible for assessing referred patients for appropriateness
- The RITH Team is responsible for prioritising patients for RITH if a waiting list is in place

2. Process:

2.1. RITH Patient Load:

- A maximum of 20 patients will be on the program at any one time during the 6 week rehabilitation period for the first 12 month period (to March 2013)
- 160 packages will be available for the first 12 month period (to March 2013)
- The maximum number of patients on the program, and number of packages available annually will be determined by the RITH steering committee following the 12 month evaluation

2.2. RITH Inclusion Criteria:

- Age over 16.
- History of recent injury, illness, surgery, exacerbation of a chronic condition or be at risk of imminent admission to the hospital setting.
- Be clinically stable and ready for rehabilitation – at the discretion of the rehabilitation physician.
- Treating medical/surgical/rehabilitation team agree for patient to be discharged with the support of the RITH team.
- Live within SVH and POWH catchment boundaries.
- Consent to receive their rehabilitation at home and/or have the agreement of their carer/family.
- Have the desire and ability to actively participate in the rehabilitation program.
- Have identifiable rehabilitation goals that can be reasonably achieved within a maximum of 6 weeks.
- Possess a level of function/independence at the commencement of the RITH program to facilitate a safe discharge home.
- Have the required community support and equipment in place to facilitate a safe discharge home.
- Have a safe home environment as assessed through the environmental checklist and/or Occupational Therapist home visit prior to discharge.
- Be sufficiently clinically stable to tolerate therapy daily.

- Must have sufficient cognitive and learning capacity to benefit from a rehabilitation program – at the discretion of the rehabilitation physician.
- An interpreter must be available during the initial assessment or subsequent therapy times at the discretion of the therapists. Health Care Interpreter services will be utilized by phone only.
- Require at least two of the following therapies*:
    - Physiotherapy
    - Occupational Therapy
    - Social Work
    - Rehabilitation Nursing

**Speech therapy, Neuropsychology, Clinical Psychology, Clinical Nutrition services can be provided on a sessional basis.*

2.3. RITH Exclusion Criteria:

- Febrile > 38.5^{o}C in last 24 hours
- Glasgow Coma Scale < 13
- Post Traumatic Amnesia (PTA) duration greater than 2 weeks – (on case by case basis)
- Traumatic Brain Injury (TBI) with behavioural issues
- Traumatic Spinal Cord Injury (SCI)
- Discharge to high level aged care facility
- Otherwise assessed as a risk for discharge home, or a greater than 6 week LOS on the RITH program (at the discretion of the RITH coordinator and/or regional Rehabilitation MO)

2.4. RITH Referral procedure:

1. Referrals to the RITH team will only be accepted from either the Inpatient Rehabilitation Consultation (IRC) team or Mobile Rehabilitation Team (MRT) at SVH or POWH.
2. Patients in the acute wards of these hospitals are to be referred to the IRC or MRT team for assessment.
3. The IRC or MRT will advise the RITH coordinator of appropriate referrals.
4. Once assessed by the RITH coordinator, the coordinator will liaise with the relevant RITH rehabilitation physician.
5. Once accepted by the RITH team, the coordinator will liaise with the home team regarding the program start date.
6. The RITH coordinator will liaise with the clients Local Medical Officer (LMO) to advise of the program and involve the LMO, where appropriate, in case conferencing.
7. Clients residing in RITH catchment who are patients in hospitals other than SVH or POWH must be referred to SVH or POWH for rehab assessment prior to acceptance on to program.
8. In the event of a waiting list for admission to the RITH program, priority will be given to:
    a. Patients at imminent risk of admission from community
    b. Acute program patients
    c. Sub-acute program patients
    d. Community.

3. Compliance:

Compliance with this procedure will be monitored by the RITH Steering Committee, and will be assessed at 3 months post commencement of the program, and annually thereafter. Compliance will be monitored with the following measures;

- Number of patients referred
- Number of patients accepted into the program
- Number of occasions patients > 6 weeks on the program (? Individual case review required)
- Number of occasions patients withdrawn < 6 weeks on the program (? Individual case review required)
- Number of occasions priority is enacted due to waiting list

4. References:

- **Supporting Evidence:**

- **ACHS EQuIP/Aged Care Standards:**

  1.1.2 Assessment ensures current and ongoing needs of the consumer/patient are identified

  1.1.3 Care is planned in collaboration with the consumer/patient and when relevant, the carer, to achieve the best possible outcomes

  1.1.5 Processes for clinical handover, transfer of care and discharge address the needs of the consumer/patient for ongoing care

  1.1.6 Systems for ongoing care of the consumer/patient are coordinated and effective

- **Related SVH and SV&MHS Policies:**

- **Related SVH and SV&MHS Procedures:**

- **Related risk register identification/incident number:**