Attachment Program for Allied Health Professions in Rehabilitation Services

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NSW GOVERNMENT
Health
Western Sydney
Local Health District

BANKSTOWN
HEALTH SERVICE
MAIN ENTRANCE
Bankstown

Pathway of a Stroke Patient

ED
RRS

Bankstown
Lidcombe
Stroke Unit

Transition
Aged Care

Residential
Aged Care +
Connecting
Care
Program

Aged
Care
Home
Rehab

Stroke
Support
Group

ACAT

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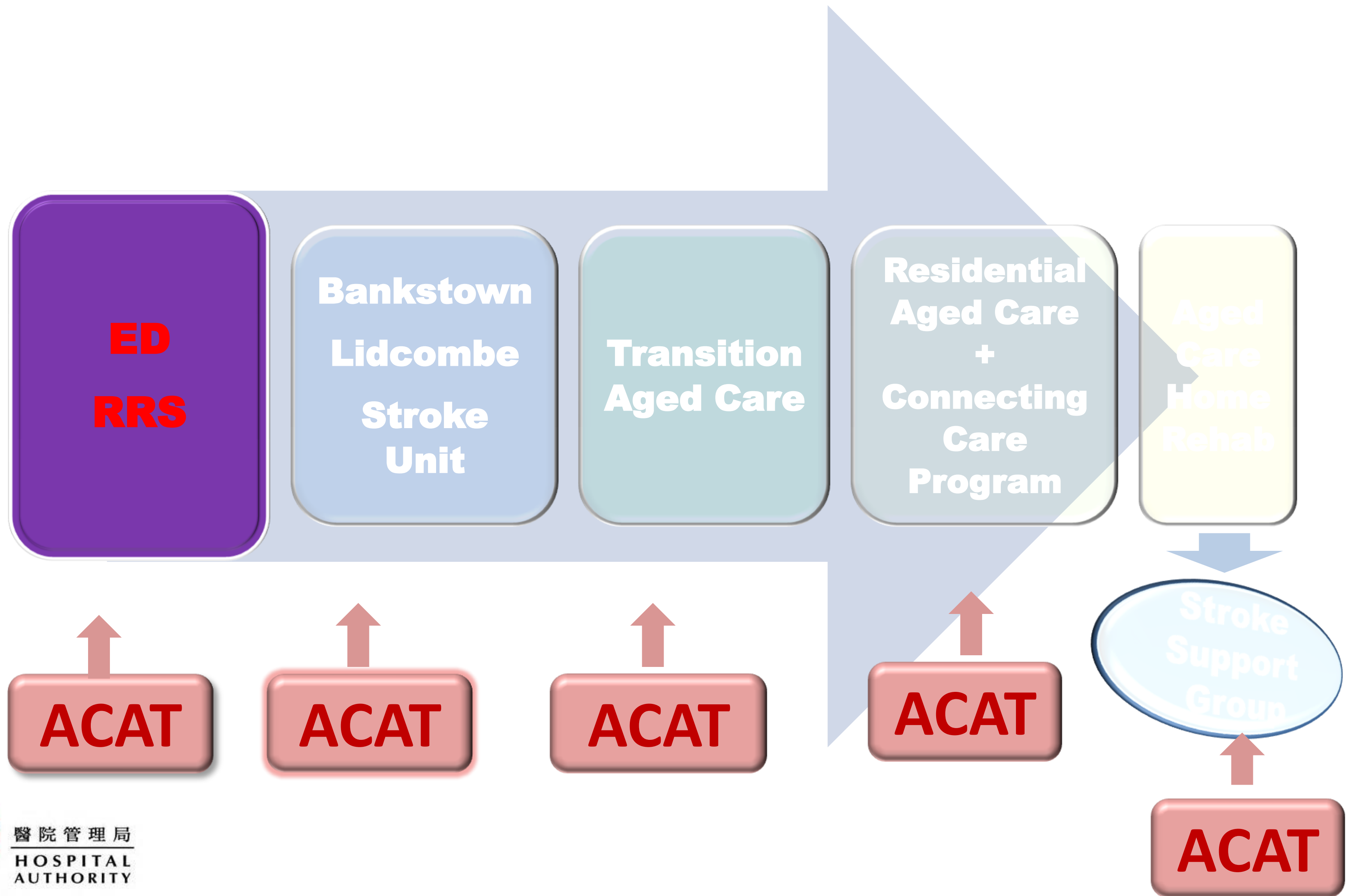
Pathway of a Stroke Patient



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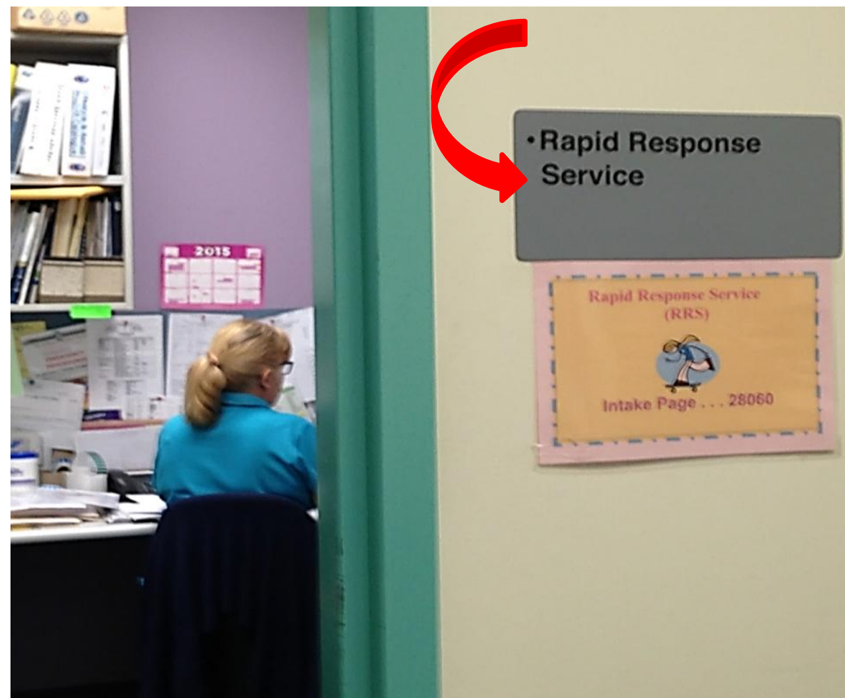
Pathway of a Stroke Patient - ED

Admitted via **ED** on Sunday

Rapid Response Service (RRS)



- ☺ **PT and OT & ST (on-call basis): Offer prompt consultation**
- ☺ **7-day service, limited cover on public holidays**

→ Achieve early discharge from ED

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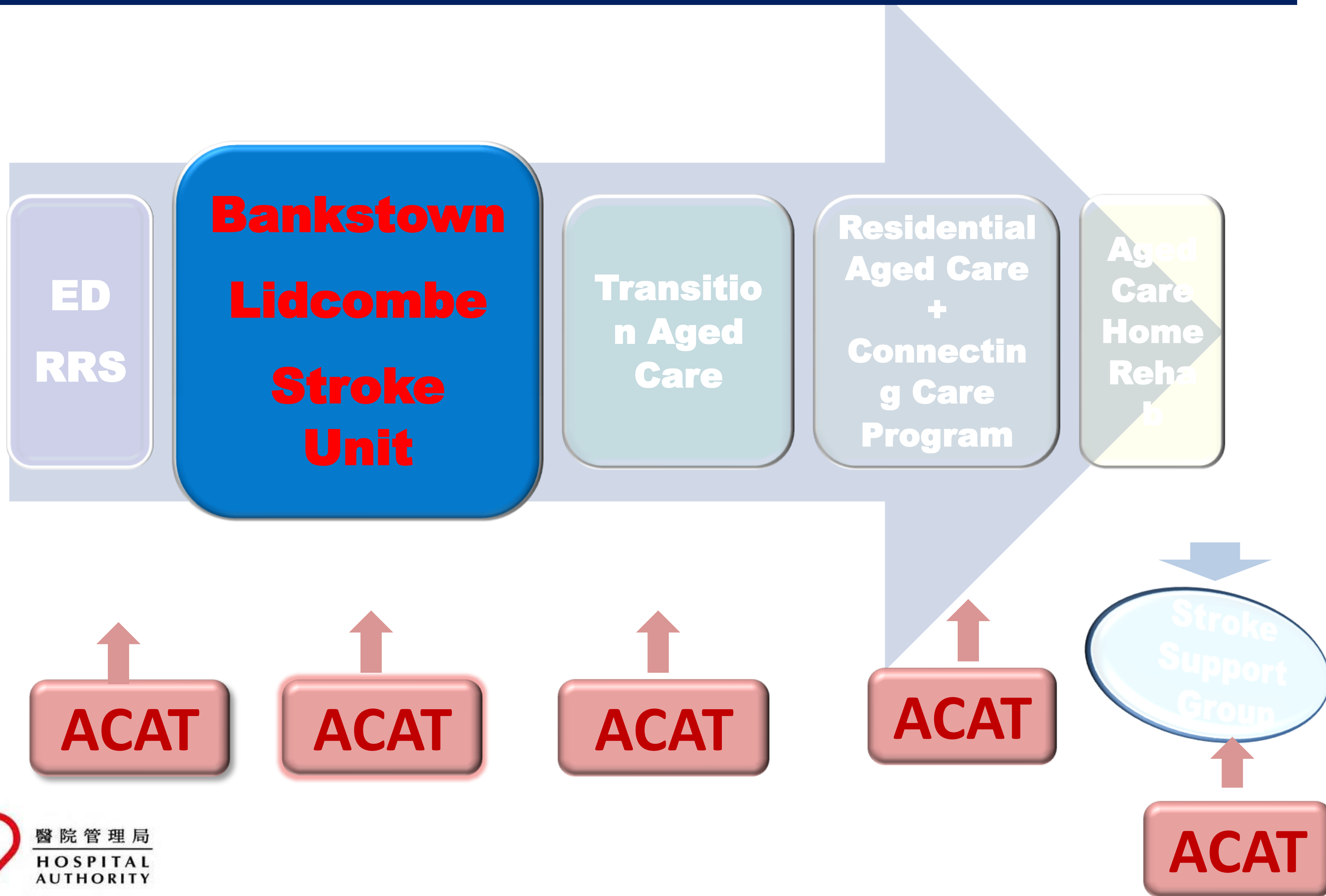
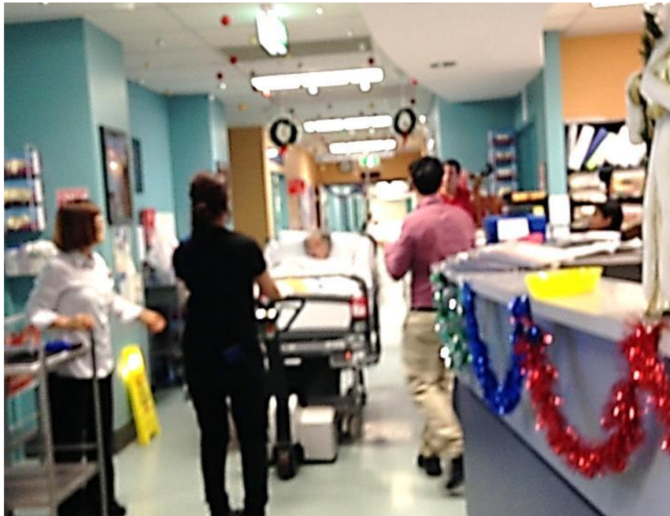
Pathway of a Stroke Patient



Bankstown-Lidcome Stroke Unit



- Stroke patient admitted directly to the unit from A&E
- Provides acute medical management & rehabilitation
- Intensive rehabilitation often starting on Day 1 or once the medical condition stable

Bankstown-Lidcome Stroke Unit

Physiotherapy

3 FTE

1:1 training session

Group session

2x/day

Closely work with caregivers

Occupational Therapy

2.5 FTE

Upper limb & ADL training (individual.gp)

Pre-discharge planning, e.g. home visit

Education aims to improve

quality of life

Speech Therapy

3 FTE

Service for swallowing and communication

Dining program

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Bankstown-Lidcome Stroke Unit Rehab with Orthoptics

- Member of acute stroke team
- All stroke patients receive a visual assessment

Services :

- ➢ Screen any visual problem for TIA & CVA cases
- ➢ Provide special glasses for neurological impairment
- ➢ Assess patients' visual acuity for driving fitness
- ➢ Visual training

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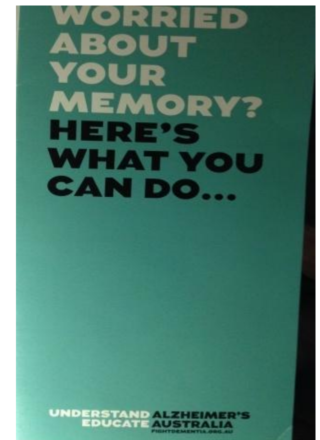
Rehab with Clinical Psychologist

- 1 clinical psychologist &1 neuro-psychologist
- Provide service on referral basis



- Need input from CP:
  - ➢ Dementia Advisory Service (DAS)
  - ➢ Specialist Mental Services for Older Persons (SMHSOP)

Interdisciplinary Bedside Rounds

- SIBR: bedside round

- Team members :
  - ✓ MOs
  - ✓ Nursing staff
  - ✓ Allied Health staff
  - ✓ +/- pt's family
  - * Early pt/caregiver involvement on D/C Plan

Structured Interdisciplinary Bedside Rounds (SIBR)

Monday & Thursday 9:30am

Ward 2B

1 Introduction

2 Review of issues test results

3 Update current status

4 Patient Safety Checklist

5 A Plan for the Day is developed

certainty
knowing what to expect

empowerment
having more say

involvement
being part of the team

confidence
talking the same language

insafe hands

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Interdisciplinary Conference

- Rehab meetings held weekly to plan rehab goals, discuss patient progress , coordinate D/C planning
- Average L.O.S (Acute + in-pt rehab.) : ≤ 21 days
- Also serves as pre-meeting among staff before family conference

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Special Features of Bankstown-Lidcombe Hospital Stroke Unit

- Same ward (acute + rehab care) and same team of stroke staff
- Shifted early from acute to rehabilitation

- Patient: **no need for adjustment** to environment and staff
- **Early initiation of rehabilitation** in the unit
- **Intensive therapy** starting in acute care
- **Reduced LOS** from 28 to 18-20 days
- Better gain in the **functional outcome**

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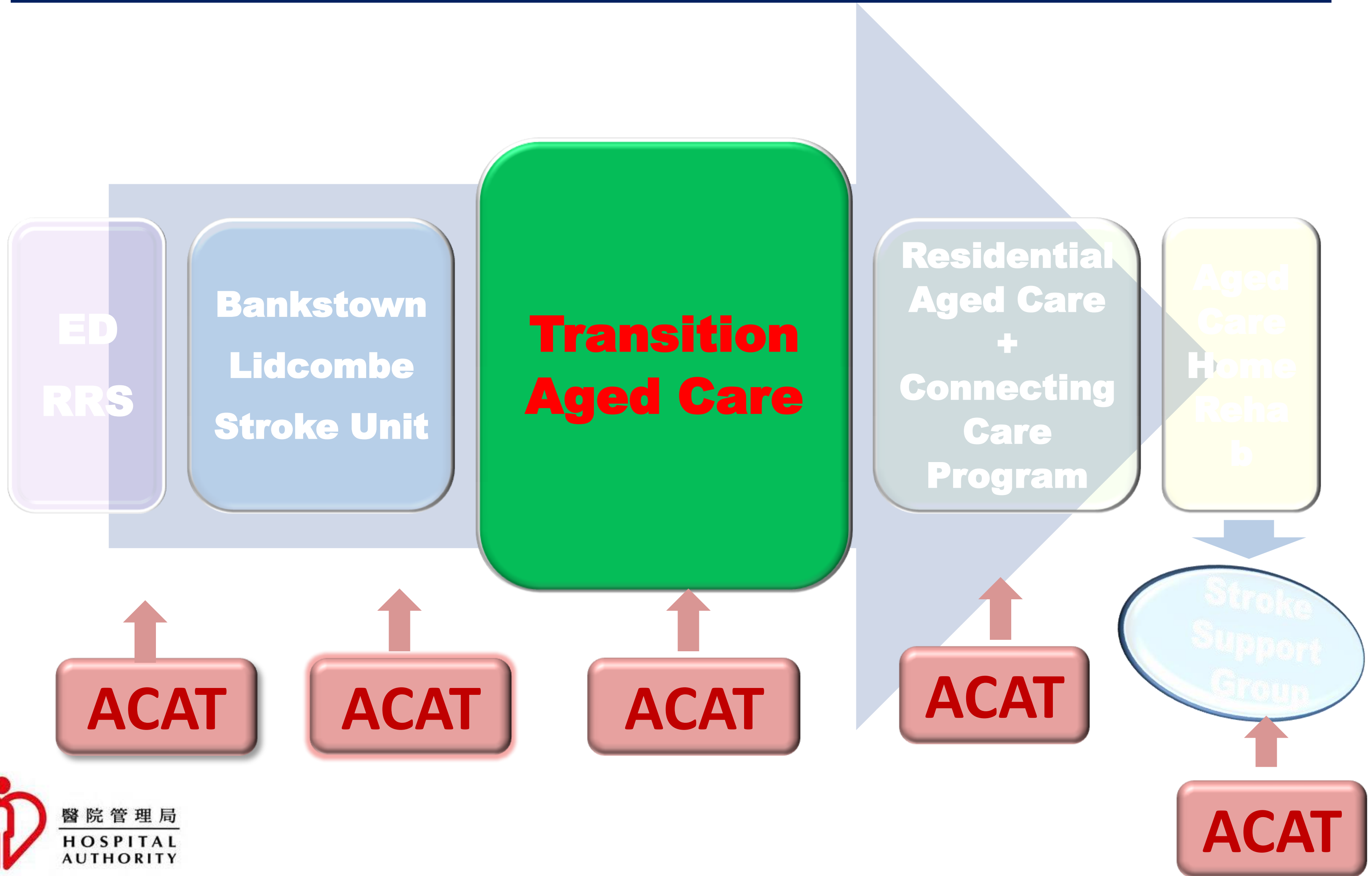

Transitional Aged Care Program (TACP)

- Up to 12 weeks of care
- Buy “rehab beds”. Government-funded
- Personnel: MO,case manger, ST, OT, PT, social worker
- Family involved in case conference

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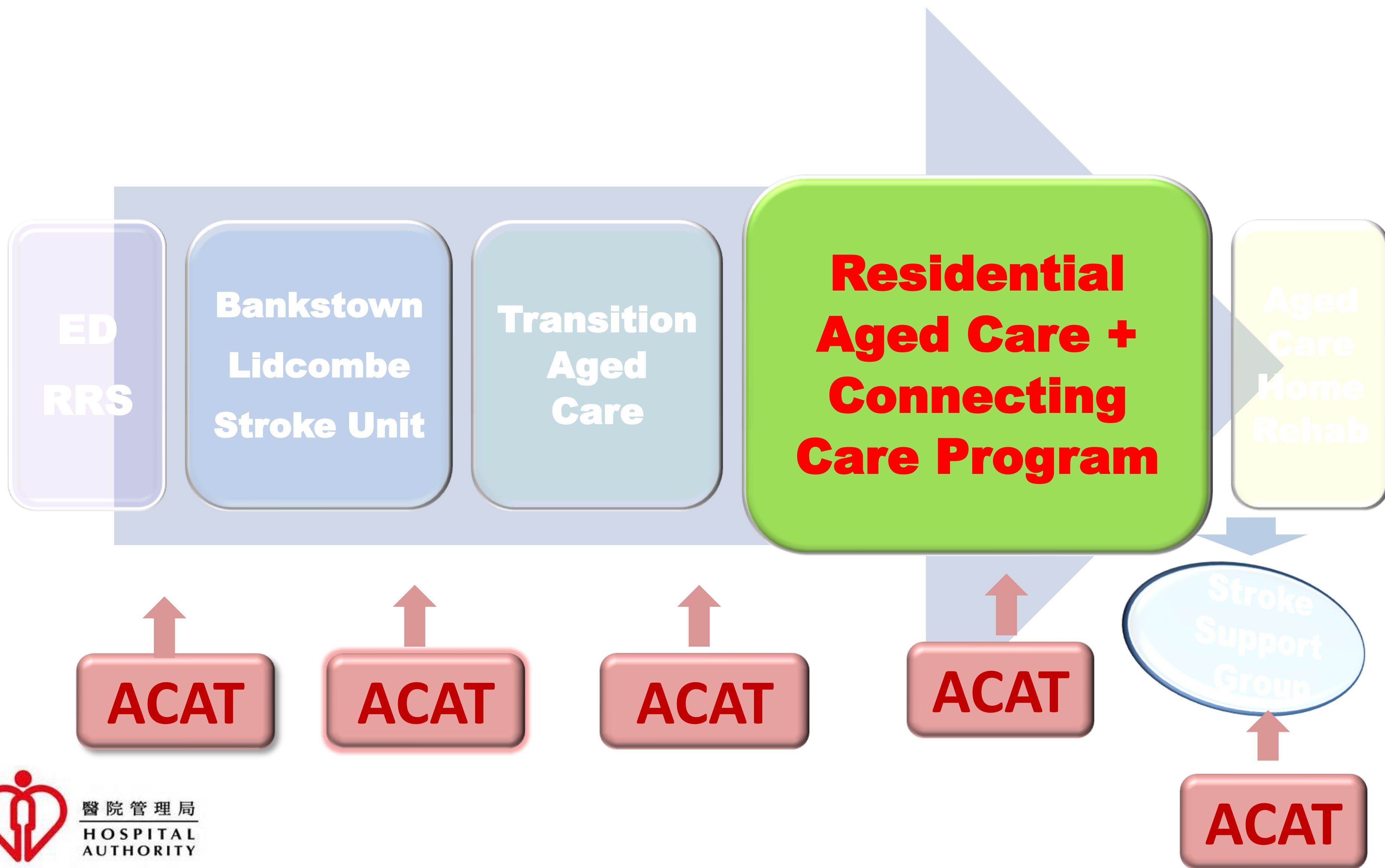


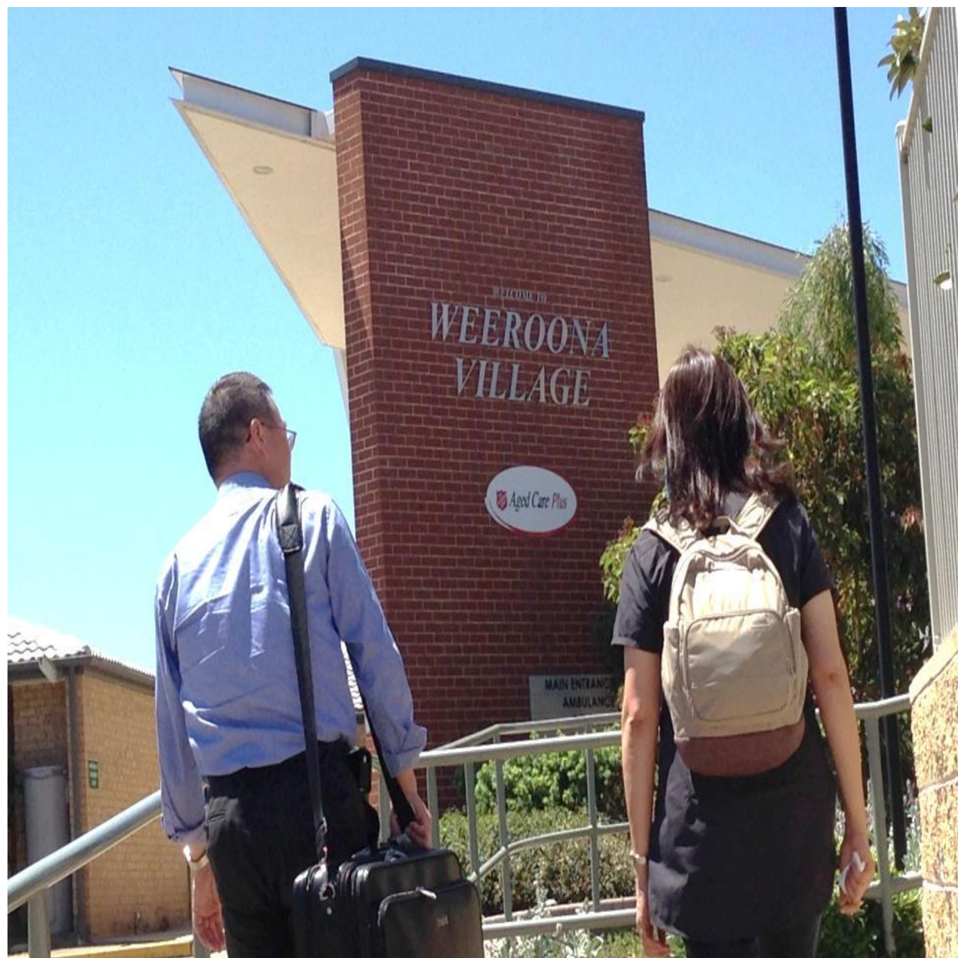
Residential aged care

Low level care (hostels) and
high level care (nursing homes)

Elderly over the age of 65

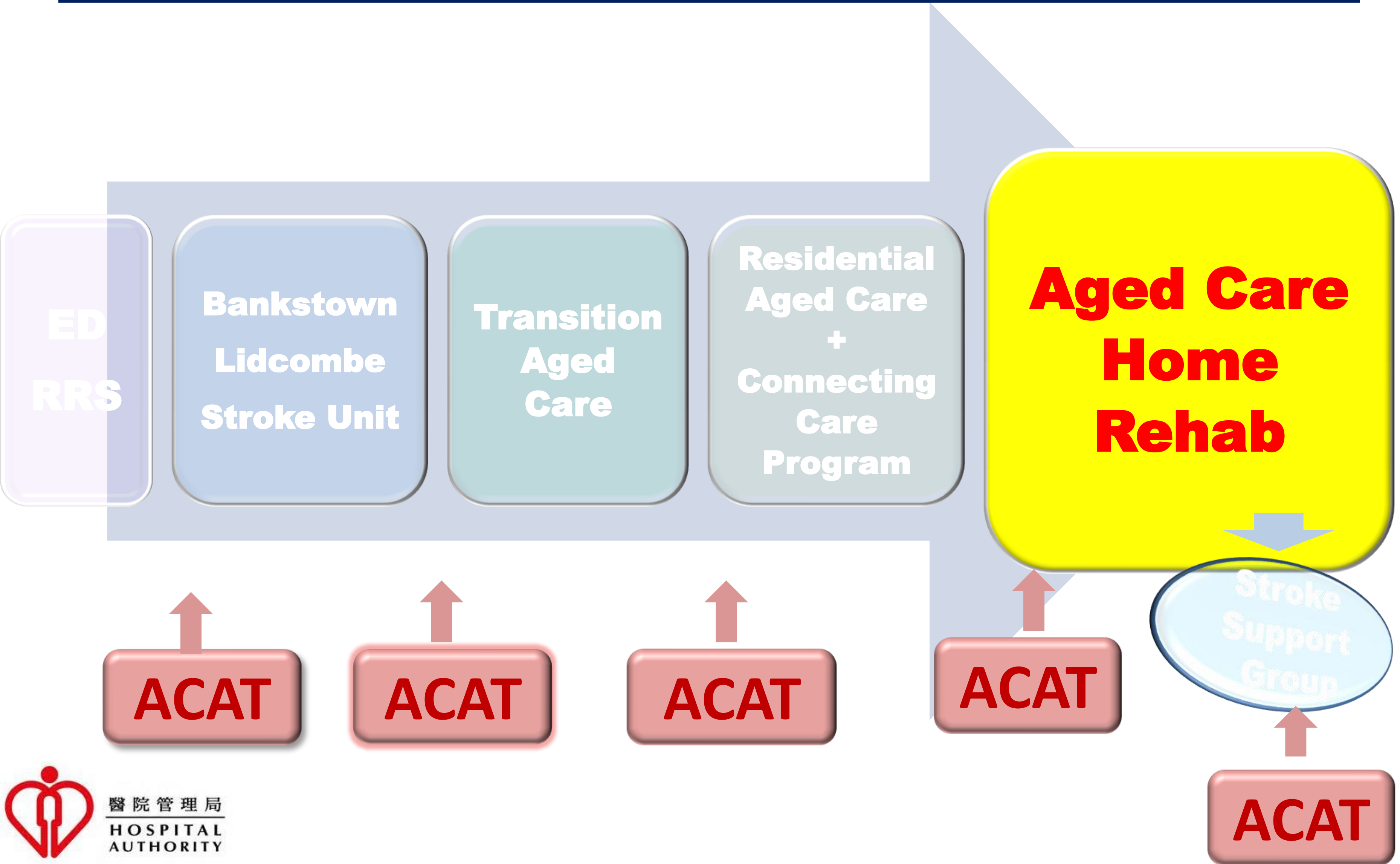
- Provides accommodation, personal and nursing care
- Most established by non-government and non-profit organizations
- AH services: PT, OT, ST, Cl Psy, Dietitian, Diversional Therapist

Residential aged care: Geriatric Connecting Care on May, June, July in 2015



- New initiative program
- Geriatrician out-reach consultation at nursing homes for acute condition
- On-call basis
- AED shows support

Pathway of a Stroke Patient



Aged Care Home Rehabilitation

- Target: elderly over 65 & young disabled aboriginal

- Commonwealth Home Support (Entry Level): house work, personal care, meal preparation, *allied health and social support etc.*

- Home Support Package (more complex): personal care, support service and allied health*, nursing clinical services*

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Aged Care Home Rehabilitation

Multidisciplinary Team

Medical Officer

GP

RN

PT

OT

Social worker

Aged care liaison officer

Speech Pathologist

Neurologist

Podiatry

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Stroke Support Group

For educational, resources, emotional support
OTs act as facilitators

Take Home Thoughts

- **Comprehensive coverage of AH Services**
  - ED, Transitional stage, Residential stage & Community
- **Start stroke rehab very soon in acute phase**
- **Provide the weekend/holiday AH service & establish flexible employment terms to facilitate 7-days manpower coverage**

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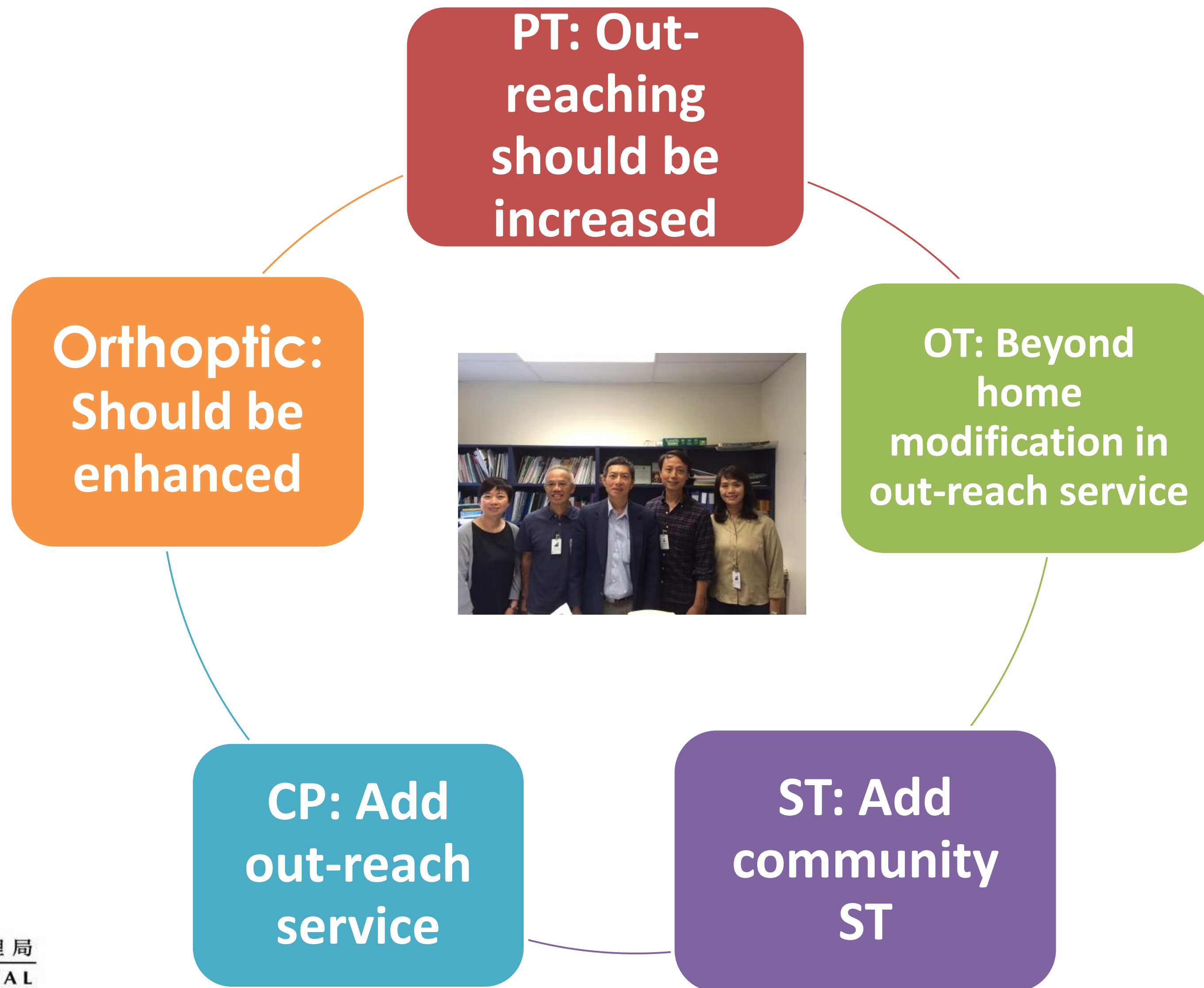
Sharing – Clinicians (Implication to Hong Kong)



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THANK YOU