ACUTE PHASE / TRIAGE

All Hip # patients identified by Triage early in admission - Enter & track on CART

Triage assessment within 48Hrs of surgery

Accept receipt of Triage assessments from other Networks

Rehab options, expected LOS, requirements on D/C discussed with — patient, family, carer

If declined—access to meeting with a Rehabilitation Consultant

Ortho Geri Team Initiate osteoporosis treatment

Cognitive screen

For acute delirium (4AT completed) delirium management protocol implemented

Pain management optimised

Handover – transition of clinical information / Triage assessments (includes equipment, Bariatric)

Identify (refer to acute AH processes) — home safety, social issues, barriers to D/C

Early referrals prompted (includes indigenous services)

Pull to Rehab (aim transfer to inpatient by day 3 post op)

Pathway — default / 1st consideration to ambulatory (refer to inpatient, home, day rehab criteria)

REHABILITATION HIP # PATHWAY - CHECKLIST ✔

4AZ3—Weighted FIM Motor 13-18 Age >65
LOS TARGET = 32

4AP1—Major Multiple Trauma
LOS TARGET = 35

4AZ4—Weighted FIM Motor 13-18 Age <65
LOS TARGET = 53

4AH1—Ortho # FIM Motor 49-91 Cog 33-35
LOS TARGET = 13

4AH2—Ortho # FIM Motor 49-91 Cog 5-32
LOS TARGET = 15

4AH3—Ortho # FIM Motor 38-48
LOS TARGET = 22

4AH4—Ortho # FIM Motor 19-37
LOS TARGET = 26

INPATIENT / HOME REHAB

DAY OF REHAB ADMISSION

Pre arrival handover — a.m. brief
Key worker assigned (within 24 hrs)

70% Transfer in before 11.30

Build on handover / assessments received. Minimise duplication Assessments include —medical, medications, pain, cognitive, risk, self care, chronic disease management

Dietetics referral

Falls risk assessment—preventative strategies

Transfer / Mobility assessment Preliminary discussion re goals as part of assessment: achieve safe mobility for discharge

Seen by Consultant within 24 Hrs—check osteoporosis treatment

Activity / therapy / functional retraining commenced

New patient screen

I-Pad provided (device set up)

Equipment review and set up

Up to 72 Hrs POST ARRIVAL

FIM Assessment

Establish goals with patient

(Multi-D) - maximize function and ensure safe discharge to final destination

Care plan / journey document initiated by Key worker. Therapy time table initiated

Social worker — Consider early referral to TCP / DSA. Consider family meeting

1st case conference - FIM review, SN Class identified, D/C plan established

Expected LOS communicated to patient (Consultant) / family (KW) / team

Activity / therapy / functional retraining / hydro / group / self directed, aim for no restrictions re level of assistance

Consider OT home visit

Early flag to ambulatory Rehab and Tele-Rehab / other therapy options, Identify carer training needs

Care plan / journey document within 24 Hrs

Seen by medical officer within 48 Hrs (Telehealth)

Daily visits (up to multiple)

PROGRESSION

Daily brief — core staff

>120 mins therapy daily

Structured activity — evenings

Consultant review and Case Conference x2 weekly

Dietetics—bone health education

6 day a week medical ward round (driving discussed)

Key worker facilitates carer training

Team provide falls education / exercise program

Other risk factors (e.g. bowel, bladder issues) managed

Team facilitates coaching — self management

Early flag to ambulatory Rehab Tele - Rehab / other therapy options

Regular goal review — key worker

Regular Consultant review as required

7 day interventions

PRIOR to DAY of D/C

Clear plan — transition from walking aid and falls prevention strategies

Bone protection treatment (med acronym expansion) —refer to Fragility # clinic if needed

Medications ordered / Pharmacist education

Patient experience questionnaire captured

Arranged — ongoing therapy, support services, follow up appointments, equipment, anticoagulation management,

D/C transport

D/C summary completed

End FIM / AROC completed

DAY of D/C

Care plan updated. Acute and Rehabilitation D/C summaries handed to patient

Meds provided

Informed — post D/C contact.

10 am D/C

DAY REHAB

AROC / Lawton's captured

No formal assessment – handover from other rehab services

Transport not a barrier to accessing services

Client centred scheduling

Maximise telehealth

Push coaching model

Continued falls risk factor modification

Return to baseline mobility

Osteoporosis follow up Post discharge telephone review At 7 days

Community Services—Day Therapy/ External Therapy/Support providers