Rehabilitation

Clinical Services Plan

2017–2022

REFRESH 2021

Metro North Health

Queensland Government

Published by the State of Queensland (Metro North Hospital and Health Service), July 2021.

This document is licensed under a Creative Commons Attribution 3.0 Australia licence.

To view a copy of this licence, visit creativecommons.org/licenses/by/3.0/au

© State of Queensland (Metro North Hospital and Health Service) 2021

You are free to copy, communicate and adapt the work, as long as you attribute the State of Queensland

(Metro North Hospital and Health Service).

For more information, contact:

Health Service Strategy and Planning, Metro North Hospital and Health Service, RBWH, Butterfield Street, Herston Qld 4029, email MNHHS_PlanningStrategy@health.qld.gov.au, phone (07) 3647 9557.

For an electronic version of this document please email MNHHS_PlanningStrategy@health.qld.gov.au

Disclaimer:

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence) for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

Contents

1. Introduction

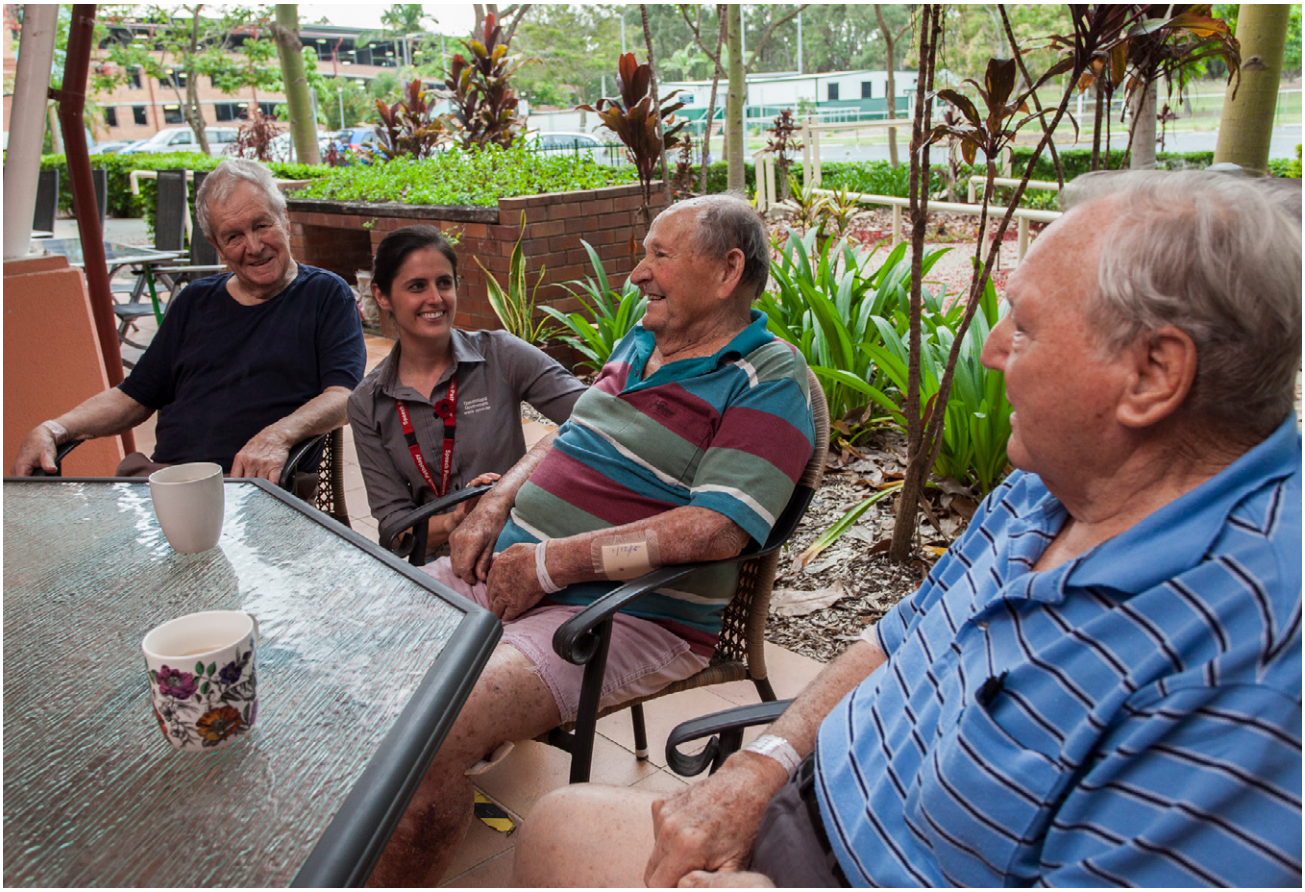
Rehabilitation services help individuals minimise the loss of physical and cognitive function resulting from illness or injury and therefore are essential for maximising patient outcomes and quality of life. Rehabilitation services also contribute to health system efficiency by enabling increased medical and surgical service activity through reducing unnecessary acute care length of stay and minimising exposure to risks associated with acute care environments such as falls and infection.

Supporting the rehabilitation needs of the community is a priority for Metro North Hospital and Health Service (Metro North).

The *Metro North Rehabilitation Clinical Services Plan* (the Plan) is a five-year plan focussing on adult rehabilitation in Metro North. The Plan has guided service development, service improvement and clinical redesign for rehabilitation services in Metro North. It incorporates recommendations from the *Statewide adult brain injury rehabilitation health service plan 2016-2026* and the S*tatewide adult spinal cord injury health service plan 2016-2026*.

Overarching documents such as *My health, Queensland's future: Advancing health 2026*, the *Metro North Strategic Plan 2020-2024*, *Metro North Health Service Strategy 2021-2026* and P*utting People First Strategy 2018* provides overarching strategic directions that informed the refresh of the Plan.

In 2020, the Metro North Rehabilitation Sub Stream facilitated a refresh of the Plan in order to understand and celebrate what has been achieved in the past 3 years, document the ever changing rehabilitation and health care environment and identify the key priorities and focus areas for the remaining 2 years of the plan.



What's been achieved?

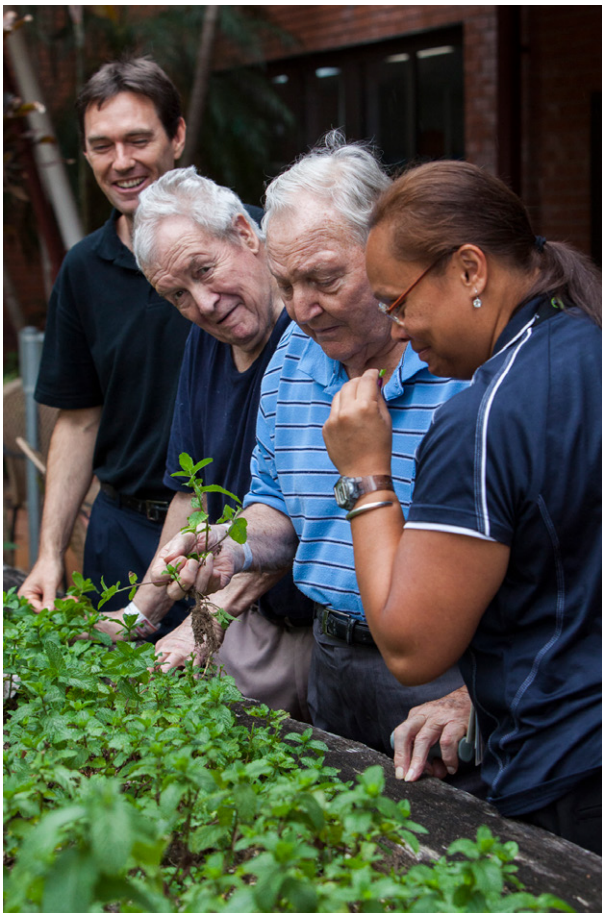
There have been a number of significant achievements in relation to rehabilitation services through implementation of this plan since 2017, including:

- Building a dedicated CSCF Level 5 rehabilitation facility within Metro North. In 2021, the stand alone RBWH GARU and GEM units relocated to STARS (Surgical Treatment and Rehabilitation Service).
- Transition of the previously known Jacana Brain Injury Service at Bracken Ridge to the Brighton Brain Injury Service. This has brought all the Community and Oral Health inpatient (bedded) rehabilitation services to the same campus enabling greater flow of patients, staff and skills across the services. The Brighton Brain Injury Service has worked successfully with NDIS community pathways to find appropriate and safe discharge destinations for patients, enabling greater access for MN to the acquired brain injury rehabilitation service and the expert NDIS community pathways team.
- The review and modification to the division of Residential and Community Transitional Care packages to promote greater capacity to meet the Metro North needs and provide improved internal flows and care coordination between the services. The previous 140 Commonwealth packages were evenly split between the services (70:70). This now sits at 60 Residential and 80 Community packages. There is now flexibility where a proportion of care packages can be deployed in either setting based on referral volume, service capacity and patient need. In conjunction to this, the Residential TCP beds were relocated from Brighton to Zillmere in 2018.
- Metro North Australasian Rehabilitation Outcome Centre (AROC) report developed that includes key performance metric for all inpatient rehabilitation services.

In addition to providing excellent patient care, Metro North has a strong culture of undertaking research and being engaged in education activities.

These activities are developing the evidence and workforce required to provide high quality rehabilitation care, in Metro North and elsewhere, now and into the future.

See appendix 1 for all completed actions.



1.1 What is rehabilitation?

The definition of rehabilitation used for this Plan is taken from the Queensland Health Admitted Patient Data Collection (QHPADC) document as:

> *Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.*
>
> *Rehabilitation care is always:*
>
> - *delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and*
> - *evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.*[1]

Rehabilitation is provided in a range of settings and involves a multidisciplinary health care team.

Inpatient rehabilitation services

In an acute care setting, clinicians can provide restorative therapy and prevent function decline for inpatients of acute care wards during illness or post-surgery. Subacute inpatient rehabilitation service capabilities are described in the Queensland Clinical Services Capability Framework (CSCF)[2] rehabilitation service module.

Level 6 rehabilitation services provide specialty and subspecialty inpatient and ambulatory settings, including complex multidisciplinary day-only treatment, subspecialist outpatient clinics and specialist community outreach programs.

Level 5 rehabilitation services also provide specialty and subspecialty ambulatory and/or inpatient rehabilitation care including outpatient clinics and multidisciplinary day-only therapy programs. Level 4 inpatient rehabilitation services provide services to clients with moderately complex care needs in acute or post-acute phases in designated units.

Ambulatory rehabilitation services

Ambulatory rehabilitation services do not involve an overnight stay at a hospital. Patients may travel to facilities to access services on the days they are required, or rehabilitation services can be provided at the patient's home. Day therapy at hospital sites has the advantage of providing access to collocated outpatient services such as specialist clinics and imaging and diagnostic services.

Locating ambulatory services in community centres can improve efficiency by enabling clinicians to treat more patients per day, reducing travel time for patients. Home-based rehabilitation involves multi-disciplinary teams that are able to observe patients interacting with their normal environment and for specific functional deficits to be identified and addressed either in person or via telemedicine facilities.

Other rehabilitation services

Rehabilitation may be a component of care provided to patients in the Transition Care Program (TCP) which is a time-limited service for patients who have been admitted to a hospital and may benefit from low-intensity therapy, nursing support or personal care before returning to their home.

It may also be a component of care in a Geriatric Evaluation and Management (GEM) program, in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with age-related medical conditions.

[1] Australian Institute of Health and Welfare 2013. Development of nationally consistent subacute and non-acute admitted patient care data definitions and guidelines. Cat. no. HSE 135. Canberra: AIHW.

[2] Queensland Health. *Clinical Services Capability Framework for public and licensed private health facilities (CSCF) v3.2* https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/service-delivery/cscf/cscf-fundamentals-of- the-framework.pdf

2. Current services

This section describes the range of rehabilitation services currently provided in Metro North.

Inpatient rehabilitation services

Acute wards therapy services

Allied health staff at all Metro North inpatient facilities provide restorative therapy and prevent functional decline for inpatients of acute care wards.

Acute stroke units enable multidisciplinary teams with expertise in stroke management to commence therapy from the time of patient admission to acute care. Acute stroke units are located in Royal Brisbane and Womens Hospital (RBWH) The Prince Charles Hospital (TPCH), Redcliffe and Caboolture Hospitals.

Patients can be discharged to subacute inpatient rehabilitation services or directly home with outpatient treatment in a day hospital, allied health clinic, community health centre or home-based care if further therapy is required.

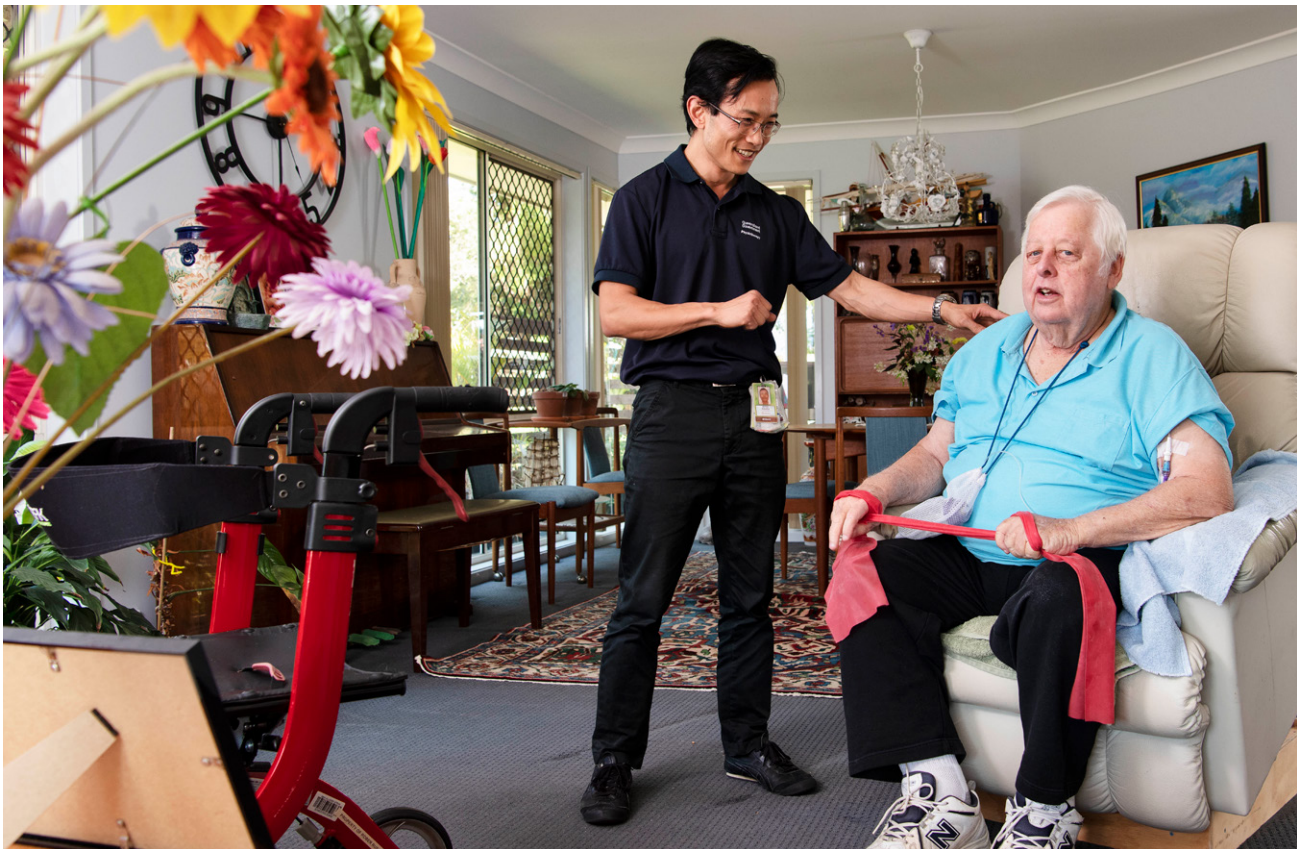
Subacute inpatient rehabilitation services

Subacute inpatient rehabilitation services are provided at four facilities in Metro North. All services are CSCF Level 4. Redcliffe Hospital has 14 beds, STARS has 30 beds at the Herston Campus, TPCH has 23 beds, and there are 50 beds at the Brighton Health Campus (42 designated for rehabilitation and 8 rehabilitation beds for the Brighton Brain Injury Service).

Ambulatory rehabilitation services

Centre-based ambulatory rehabilitation services

Day hospital services are provided at two locations in MNHHS. The STARS Geriatric and Rehabilitation Services operates an ambulatory rehabilitation service on the ground floor of STARS, as well as specialist clinics for rehabilitation assessment, falls and hypertonicity. The Prince Charles Hospital Rehabilitation Day Therapy Unit is located at Chermside.



The Community Based Rehabilitation Team (CBRT), provide home or centre-based rehabilitation from four locations around Metro North: Caboolture, Redcliffe, Chermside and North Lakes, for people who are not admitted to a hospital or attending hospital outpatient clinics. Patients are assessed and allocated to programs of up to 12 weeks duration depending on their individual rehabilitation needs. Currently, if ongoing rehabilitation is required patients must be referred on to centre-based (day hospital) ambulatory services.

The specialist needs of patients, who have had limb amputation, including rehabilitation, are addressed by the RBWH amputee service in conjunction with community-based rehabilitation teams (CBRT). The RBWH amputee service supplies and manages interim prostheses and facilitates the provision of long-term prostheses. Multidisciplinary outpatient review clinics are provided at the RBWH and Redcliffe Hospital. Outreach services are also provided at Nambour and Toowoomba Hospitals. Amputee rehabilitation services are provided by CBRT at Redcliffe Community Health Centre, North Lakes Health Precinct and King Street Community Health Centre, Caboolture.

Home-based ambulatory rehabilitation services

CBRTs also provide home-based rehabilitation services for up to 12 weeks. Post-acute care services (PACS) provide home-based therapy services for up to two weeks following hospital presentation.

Associated services

The following associated services are not in scope for this plan however they have a role in providing a comprehensive and integrated range of rehabilitation services in Metro North.

Geriatric and rehabilitation liaison service

The geriatric and rehabilitation liaison services (GRLS) currently have various operating models across the Metro North facilities. The overall function is to provide comprehensive medical, nursing, functional and psychosocial assessment, with a particular focus but not limited to older persons. GRLS helps identify patients that may be ready for transfer to subacute services, which may include rehabilitation or community care, to optimise timely and appropriate transfers.

Brighton Brain Injury Service (BBIS)

BBIS provides inpatient rehabilitation and care for clients with an acquired brain injury (ABI) at the Brighton Health Campus.

Transition Care Program

Metro North has 140 Commonwealth Care packages. There are currently 60 residential TCP beds at Zillmere and 80 places for community based transitional care.

Geriatric Evaluation and Management

Rehabilitation forms part of the suite of services provided for patients of geriatric evaluation and management (GEM) units. Older patients are able to access appropriate rehabilitation services in GEM units or dedicated rehabilitation units. GEM beds are currently available at STARS, TPCH and Caboolture Hospital.

Rehabilitation engineering

Rehabilitation engineering is a statewide service operating from the Herston Campus in STARS.

The service has two main streams: postural seating modifications mostly for people with wheelchairs where a solution was not available in the commercial or non-government sectors and customised assisted technology for children. The second stream is assisting the management of skin integrity/pressure wounds for people in wheelchairs.

Non-government rehabilitation providers

A number of private hospitals, geriatricians, and allied health professionals in the Metro North region provide a range of inpatient and ambulatory rehabilitation services for orthopaedic, neurological, and cardiopulmonary conditions. Non-government organisations have been funded to provide long-term rehabilitation services for some specific patient groups.

Table 1 provides a summary of the current rehabilitation services in Metro North.

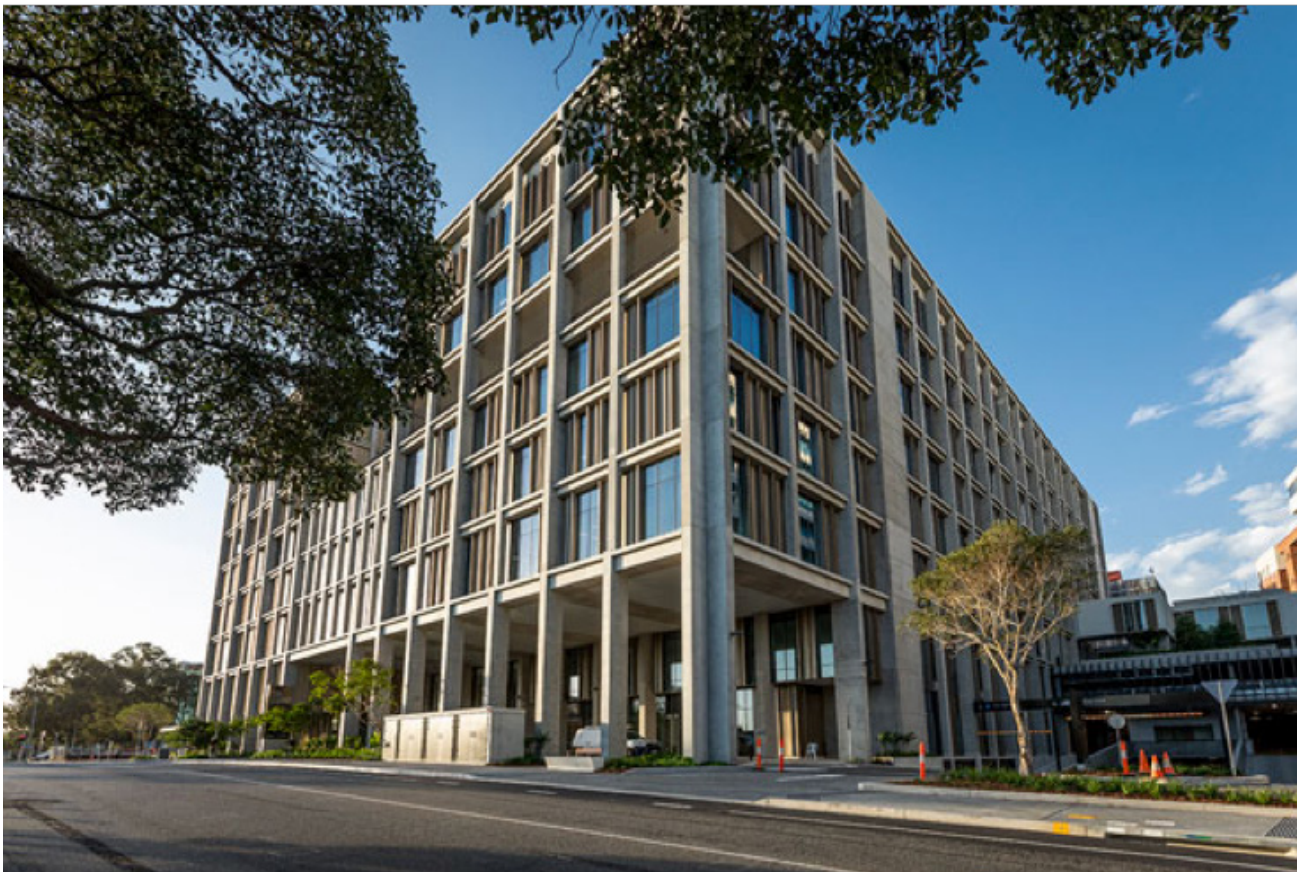
Table 1: Summary of current Metro North services rehabilitation services – March 2021

	INPATIENT		Ambulatory	
Facility	**Acute**	**Subacute**	**Centre-based**	**Centre-based**
Caboolture and Kilcoy	Limited acute ward based therapy service	Not available	King Street Community Health Centre, Caboolture (CBRT) North Lakes Health Precinct (CBRT)	Community Based Rehabilitation Teams
Redcliffe	Acute ward based therapy service	CSCF Level 4 14 beds	Redcliffe Community Health Centre (CBRT) North Lakes Health Precinct (CBRT)	
TPCH		CSCF Level 4 23 beds	TPCH Rehabilitation Day Therapy Unit Chermside Community Health Centre (CBRT)	
STARS	Not applicable	CSCF Level 4 30 beds	Chermside Community Health Centre (CBRT) STARS Day Rehabilitation Unit	
Brighton	Not applicable	CSCF Level 4 50 beds (42 rehab and 8 brain injury)	Not available Redcliffe Community Health Centre (CBRT)	
TOTAL		117 BEDS		

3. To date

From 2017 to 2020 the clinical activity and demand for subacute care across the Metro North has continued to increase, but so too has the alternatives to inpatient care. The focus has been on ensuring developing Metro North services are more agile in their implementation to ensure that the right patient can get their care in the right place.

In light of 2020 and the COVID pandemic response, virtual care, digital solutions and home-based services have needed to be prioritised and further enhancements will be required into the future planning of subacute services.



4. Current commitments

STARS is planned to expand in 2023 to include specialist rehabilitation beds including a brain injury unit.

5. Future service directions

The opportunity to refresh this plan in 2020 has enforced reflection on the current healthcare climate and prompted subacute teams to consider greater emphasis on;

- Value Based Healthcare
- Translations Research
- Interprofessional practice and care
- The use of technology, virtual care and digital applications.

Over the next two years Metro North commits to growing the capacity and capability of rehabilitation services across the care continuum. Building on the achievements of the Metro North rehabilitation services, our current services will continue to be enhanced. New models of care will be developed particularly in the home and community settings based on the needs of patients, carers and their families.

Person-centred care will continue to be a central tenet of rehabilitation service delivery in Metro North. The effectiveness of rehabilitation therapies which ultimately contributes to the quality of life patients can realise when they return to their home and community depends on the degree to which patients participate. It is therefore critical that rehabilitation services continue to engage with patients to establish their therapy goals which can include physical, emotional and social domains.

Over the next two years Metro North commits to enhancing services through the application of the following principles:

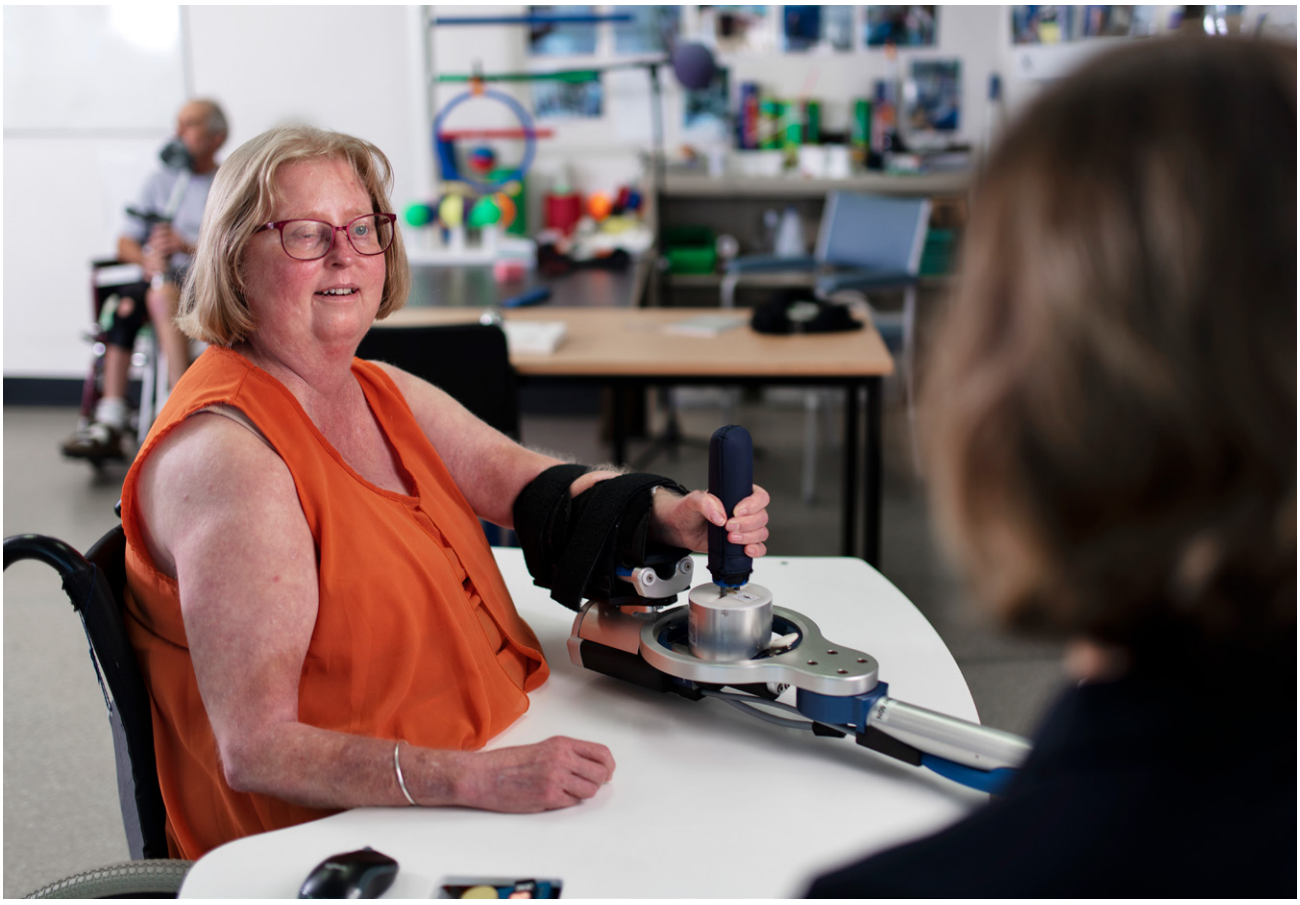
Engaged	• Put patients, carers and families at the centre of their care • Strive to provide the best possible patient experience • Engage with communities and seek input into service design so that future services continue to meet expectations • Form meaningful partnerships to support innovation • Ensure engagement gives everyone an opportunity for an equal voice including those who feel powerless and vulnerable when seeking care • Assist those accessing services to understand and act on information they are given to help them improve their health
End-to-end	• Be one Metro North, with multiple hospitals working towards the one goal of high quality, integrated and compassionate care for our patients • Provide care that is coordinated, integrated and maximises continuity • Connect with the wider service provider system so that people can access the right care provider, at the right time and in the right place
Equitable	• Enable equity of access and outcome irrespective of location, particularly for hard to reach populations and those with special health needs • Provide services locally where appropriate and possible
Evidence-based	• Standardise the patient journey/approach (pathways, processes) for common patient groups and tailor to meet the individual needs • Be evidenced-based and when there is limited evidence invest in innovation that is evaluated and measured with clear objectives for delivering defined patient benefits and outcomes

Figure 1: The Metro North rehabilitation service system following implementation of the plan

INPATIENT		Ambulatory	
Acute	**Subacute**	**Centre-based**	**Home-based**
• Specialist consulation liaison rehabilitation service • Acute ward based multi-disciplinary teams	• Specialist level 6 inpatient rehabilitation service* (STARS) • Level 4 inpatient rehabilitation services • GEMS units • Transition Care – Residential • Brighton Brain Injury Rehabiliation and Community Pathway • Private services	• Specialist outpatient rehabilitation clinics • Day hospital/therapy units • Specialist level 6 transition rehabilitation service* • Private services	• Community based rehabilitation teams • Transition care – Community • Post Acute Care Service • Specialist level 6 transition rehabilitation service • Community-based rehabilitation teams • Private services

PATIENT FLOW
Identify – Assess – Triage – Allocate – Refer

** CSCF level 6 rehabilitation services must provide specialist services for inpatient and ambulatory services that include complex multidisciplinary day-only treatment, subspecialist outpatient clinics and specialist community outreach programs.*



6. Service directions

Three service directions were identified to achieve the desired future state for Metro North rehabilitation services. A series of measurable objectives and practical evidence-based actions have been listed under each service direction; however, they may also contribute to more than one service direction and/or objective.

Together, the service principles, service directions, and objectives, provide a robust and person-centred framework for Metro North rehabilitation services, which will be built upon the foundation provided by existing services and previous subacute plans, and be reinforced through the implementation of a comprehensive suite of evidence-based actions.

The Medicine Stream will have oversight of the service directions included in the plan, however responsibility will sit with service directors.

The service directions are:

1: Metro North will have clearly defined and integrated rehabilitation pathways across the service system

2: All patients receiving rehabilitation services in Metro North will have timely and equitable access to the most appropriate service

3: All aspects of Metro North rehabilitation services will be evidence-based and delivered efficiently

Service direction 1 | Metro North will have clearly defined and integrated rehabilitation pathways across the service system

It is common for rehabilitation patients to make a number of transitions between facilities and providers. The frequency of these transitions makes it critical that systems and processes are in place to promote the integration and coordination of rehabilitation services to optimise patient experiences and outcomes.

A consistent and streamlined mechanism for identification, assessment, allocation, and referral of patients for all rehabilitation services across Metro North, including community-based and private sector services is our priority. Defining patient pathways within the Metro North rehabilitation service network will improve patient access to the right care, in the right place, at the right time.

Strengthening integration between community-based rehabilitation services with acute and subacute inpatient rehabilitation services will be essential. Consultation liaison services and community-based rehabilitation teams will work together to facilitate a patient's health care journey, delivering coordinated and patient-centred care, creating partnerships across different health providers and sectors, improving patient outcomes and enabling improvements across the system.

Service objectives

Implement standardised rehabilitation patient journeys (pathways and processes) for common patient groups and tailor to meet the individual needs.

Enhance rehabilitation service networks across Metro North to act as one health service, with multiple services working towards the one goal of high quality, integrated and compassionate care for patients.

Enhance the rehabilitation model of care across service settings to focus on functional improvement together with the patient's social, emotional and mental well-being. This will maximise their quality of life with the goal to remain in the community for as long as possible.

Improve rehabilitation service connections with the wider health and social services system so that people can access the right care provider, at the right time and in the right place.

Actions

	2020 Refresh Priority Actions	Responsibility
1A	Review the service model and staffing profile for GRLS to promote consistency in the capability and availability of the service across MNHHS	GRLS
1B	Review and refine rehabilitation patient pathways in line with evidence- based practice and peer group benchmarks to optimise patient outcomes and make best use of available rehabilitation resources across the MNHHS	Rehabilitation Services
1C	Develop a consistent mechanism for identification, assessment, allocation, and referral of patients for rehabilitation services across MNHHS	Medicine Stream, Rehabilitation Services, GRLS
1D	Adopt, or develop, patient assessment tools and protocols for use by all rehabilitation services and referrers across MNHHS	Rehabilitation Services
1E	Develop and disseminate admission and discharge criteria, with associated referral/transfer protocols, for MNHHS rehabilitation services	Medicine Stream, Rehabilitation Services
1F	MNNHS rehabilitation services utilise patient pathways for specific impairments as part of standard practice, with tailoring of pathways where indicated to meet the individual patient needs	Medicine Stream, Rehabilitation Services
1G	In conjunction with Children's Health Queensland paediatric rehabilitation services: 1. establish formal links between MNHHS rehabilitation services and Children's Health Queensland 2. develop guidelines for the transition of patients between paediatric and adult rehabilitation services	Medicine Stream, Womens and Childrens Stream, Rehabilitation Services

Service direction 2

All patients receiving rehabilitation services in Metro North will have timely and equitable access to the most appropriate service

Access to the right rehabilitation service, in the right care setting at the right time will be enhanced over the next five years as the Metro North rehabilitation service system grows in capacity and capability. Rehabilitation services in Metro North will evolve to include timely access to rehabilitation in the following settings:

- home based rehabilitation services for patients who are able to return home safely but have limited mobility
- ambulatory day hospital and specialist outpatient services to provide intensive multi- disciplinary therapy
- the acute inpatient ward through a multidisciplinary team approach to in reach/consultation liaison services including allied health
- comprehensive multidisciplinary inpatient sub-acute rehabilitation services, including inpatient and ambulatory specialist rehabilitation services.

Service objectives

- Increase ambulatory rehabilitation service capacity across Metro North.
- Level 4 inpatient rehabilitation services are provided from facilities in all Metro North catchments.

Actions

	2020 Refresh Priority Actions	Responsibility
2A	Review of ambulatory services including CBRT, telehealth, hypertonicity services	Medicine Stream, Rehabilitation Services
2B	Increase allied health staffing at Caboolture Hospital to enable additional rehabilitation therapy to be provided to patients on acute wards while awaiting transfer to other facilities for inpatient rehabilitation	Executive Director, Caboolture Hospital
2C	Identify a suitable service setting for non-weight bearing patients and those awaiting QCAT determinations of capacity prior to discharge to residential care	Rehabilitation Services
2D	Develop a MNHHS policy on the provision of a public driver assessment service including potential revenue sources such as NDIS and workplace injury or motor vehicle accident insurance schemes	Medicine Stream, Rehabilitation Services

Service direction 3 | All aspects of Metro North rehabilitation services will be evidence-based and delivered efficiently

Outcomes for patients accessing rehabilitation services are influenced by both the quality and quantity of treatment provided for them. The dose-response principle provides the imperative for most patients for greater frequency of therapy to achieve functional gains in a shorter timeframe. Reducing delays to the initiation of rehabilitation, and to discharge once functional goals have been achieved, will further optimise length of stay and enhance rehabilitation service efficiency.

Metro North rehabilitation services currently play an important role in encouraging clinical research and educating the future clinical workforce. There is an opportunity to collaborate further with educational and research institutions to coordinate the rehabilitation research agenda to target Metro North service improvement priorities.

Collecting and reporting service outcomes in a consistent manner allows for benchmarking across Metro North and with national peers.

Working collaboratively with Metro North rehabilitation colleagues to review this information, and other rehabilitation issues, will provide the opportunity to foster innovation by drawing on different perspectives and expertise to the benefit of all services.

Service objectives

- To deliver evidenced-based services and contribute to research, innovation, and education, that is evaluated and measured with clear objectives for delivering defined patient benefits and outcomes.
- To partner with research and education institutions to support a culture of innovation and research opportunities in rehabilitation services including using technology to advance innovative models of care workforce development.

Actions

	2020 Refresh Priority Actions	Responsibility
3A	Develop evidence-based rehabilitation protocols that include guidelines for optimal service type and therapy dose (that are amenable to be tailored to individual needs) for conditions commonly managed by MNHHS rehabilitation services	Rehabilitation Services
3B	Implement discharge planning at the time of admission to inform patients and carers of the likely length of stay and facilitate patient flows	Rehabilitation Services
3C	Facilitate research projects consistent with the direction of Rehabilitation Clinical Services Plan and share relevant research and quality improvement initiatives	Rehabilitation Services
3D	Implement annual Rehabilitation Audit Team review of acute care wards at all MNHHS facilities to monitor impact of delayed transfer to rehabilitation services	Directors of Rehabilitation Services
3E	Establish formal links between MNHHS inpatient rehabilitation services and CBRT to promote communication and service integration	Inpatient Rehabilitation Services **Team Leader, CBRT**
3F	Define impairment groups and locations for trialling six or seven day- per-week inpatient rehabilitation service to optimise rehabilitation efficiency and length of stay	Medicine Stream, Rehabilitation Services
3G	Implement Patient Reported Experience Measure	Rehabilitation Services

7. Appendices

Completed Actions

Action	Initiative
1.1	Patient Access Coordination Hub includes all MNHHS rehabilitation places (beds and ambulatory places) in the patient flow monitoring system and make accessible to all rehabilitation clinicians and GRLS
2.1	Further analyse MNHHS rehabilitation service activity data by functional impairment group, and align with service activity projections, to guide organisation and resourcing of services to maximise effectiveness and efficiency
2.3	Increase capacity of ambulatory rehabilitation services to provide cardiac and pulmonary rehabilitation
2.4	Investigate opportunities to increase accessibility for centre-based ambulatory rehabilitation services by locating within a broader range of facilities such as commercial fitness centres
2.5	Increase capacity of TPCH Day Therapy Unit through maximising other space within the facility for expansion of gymnasium and clinical room utilisation
2.10.1	partner with NGOs to provide 30 residential transition care places to enable an increase in the CSCF Level 4 inpatient rehabilitation service to 80 beds at Brighton Health Campus
2.12	Transfer the 30-bed Level 4 inpatient rehabilitation service (GARU) and Day Hospital to SRACC, and increase bed capacity to a total of 60 CSCF Level 4 inpatient beds
2.14	Implement actions from relevant statewide plans such as the Statewide adult brain injury rehabilitation health service plan 2016-2026 recommendation to establish a step-down rehabilitation service. This will include a review of the Jacana ABI Unit service model.
2.15	Develop a mechanism to monitor access to rehabilitation services by hospital catchments
3.4	All MNHHS rehabilitation services collect and report Australasian Rehabilitation Outcomes Centre (AROC) data for all patients regardless of length of stay, with selected data reported according to AROC guidelines

Actions progressed through another avenue or reframed

Action	Initiative
1.3	Establish a GRLS at Caboolture Hospital
1.10	GRLS to develop and maintain an online register of local rehabilitation services, accessible to all MNHHS rehabilitation services, to facilitate communication and appropriate and efficient referrals
1.11	Develop new pathways for other identified priorities including people with mental health issues and liaise with non-government organisations to develop a pathway for patient who are slowly losing function and require long term rehabilitation.
1.13	Develop protocols and tools for the assessment and/or referral of patients by non-government providers to MNHHS rehabilitation services
1.14	Develop a medium for a patient-held record that provides rapid access to key social and clinical information to promote continuity of care with service transitions
1.15	Define key clinical and social information to be included within patient- held records

Actions progressed through another avenue or reframed (continued).

2.7	Establish specialist ambulatory (centre-based or community-based) transitional rehabilitation service capacity for ABI and Spinal Cord Injury (SCI) patients not eligible for Metro South Hospital and Health Service (MSHHS) ambulatory services, prior to the development of SRACC inpatient services
2.10.2	Establish a centre-based ambulatory rehabilitation service at Brighton Health Campus
2.10.3	Enhance/introduce clinical support services such as medical imaging, pathology and pharmacy at Brighton Health Campus
2.11	Establish a 40-bed Level 6 specialist rehabilitation service (SRACC) to provide comprehensive specialist rehabilitation for complex trauma, stroke, burns, and brain injuries, and spinal injuries patients
2.13	Complete refurbishments at Redcliffe Hospital to enable opening of further Level 4 inpatient rehabilitation beds
2.16	Develop a mechanism to monitor and address delays in access to rehabilitation services in line with evidence-based timeframes specified by MNHHS rehabilitation service pathways
2.17	Investigate opportunities to increase broader access to gait laboratory services for rehabilitation patients
2.18	Liaise with National Disability Insurance Scheme (NDIS) providers to facilitate placement of young people with a disability requiring slow stream rehabilitation or residential placement
2.20	Develop infrastructure guidelines that provide for patient-centred care, number of clinical and administrative spaces and dimensions, and appropriate bed arrangements for management of specific patient cohorts (eg bariatric and infectious patients)
2.21	Develop a MNHHS policy on the provision of a public driver assessment service including potential revenue sources such as NDIS and workplace injury or motor vehicle accident insurance schemes
2.22	Establish a driver assessment service for MNHHS which includes development of clinical guidelines for the assessment of patient capacity to drive motor vehicles, including referral for specialised driving assessment where indicated
3.3	MNHHS rehabilitation services collaborate to develop consistent clinical and business processes for hypertonicity services
3.6	Develop a mechanism to ensure regular review of rehabilitation models of care and opportunities to trial and/or adopt new and emerging practices and technologies such as robotics and telerehabilitation
3.8	Advance workforce development opportunities across disciplines with research and university partners.
3.11	Establish an integrated education, training and research program for rehabilitation services in collaboration with MNHHS workforce unit, professional leads and universities and other research institutions
3.12	Develop an information technology system that supports high quality rehabilitation care by integrating patient needs/goals, care pathways, clinical protocols, and discharge planning.
3.13	Develop consistent tools and protocols for assessing rehabilitation service performance within MNHHS, based on the achievement of patient goals (social and functional)
3.14	Improve communication across professional boundaries to foster inter- professional practice

www.health.qld.gov.au/metronorth