In-reach rehabilitation toolkit

In-reach rehabilitation model of care

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In-reach rehabilitation toolkit

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Overview of service model

This model of care draws on the NSW Rehabilitation Model of Care (NSW Agency for Clinical Innovation, 2025) and has been adapted for the Queensland context. A Clinical Advisory Group (CAG) met monthly during the six-month project, to provide structured clinical oversight, contextual advice, and consensus input, ensuring the model reflected Queensland service settings, patient cohorts, workforce capability, and governance arrangements. The CAG comprised clinical experts from both established and emerging in-reach rehabilitation services, as identified in the *Current State Analysis Report*.

The primary objectives of in-reach rehabilitation are to:

- improve patient functional outcomes; and
- avoid, or reduce, the length of stay in inpatient rehabilitation where appropriate thus improving patient flow.

Service characteristics

- The service is led by a rehabilitation physician or a senior rehabilitation clinician (HP5 Allied Health Professional or Rehabilitation Clinical Nurse Consultant) and delivers a structured, multidisciplinary rehabilitation program within acute or critical care environments.
- Care type is assigned in accordance with the Care Type Policy, based on the primary nature of clinical care and local operational protocols. Where criteria under AN-SNAP V5.0 are met, patients may be type-changed from “acute” to “rehabilitation,” subject to local health service procedures.
- In-reach services may use care-type changes to capture rehabilitation episodes once patients are assigned a “rehabilitation” care type. However, this approach may not capture all patients, including those unable to be AN-SNAP V5.0 classified due to funding constraints (e.g. overseas patients without rehabilitation cover) or ongoing medical complexity that necessitates continued acute management, or where local episode-change processes differ.

Governance and workforce considerations

- Locally established governance arrangements, procedures, and communication pathways are required to ensure alignment of care objectives and shared accountability between acute and rehabilitation teams.
- Services may consider adopting an interdisciplinary practice model; however, this requires clearly defined role expectations, governance and consideration of workforce development and upskilling. While not mandated in the statewide model of care, this approach may be implemented at an individual service level where appropriate.

Patient cohorts

The in-reach rehabilitation service is intended to support a defined group of patients who meet the criteria for intensive, goal-directed multidisciplinary rehabilitation within an acute setting. These patient cohorts may include patients:

- requiring intensive, multidisciplinary goal-directed rehabilitation following significant health event, illness or injury.
- who are medically and cognitively stable enough to tolerate therapy (usually twice daily or more), and motivated to participate in rehabilitation.
- with unclear or unknown tolerance for intensive rehabilitation requiring a “trial of rehabilitation”.
- unable to be transferred to a subacute rehabilitation service due to discharge delay or inability to access ongoing medical care (e.g. haemodialysis or tracheostomy) in the sub-acute setting.
- with bariatric care needs where suitable infrastructure is unavailable in the sub-acute service.
- that are unable to access sub-acute rehabilitation services due to financial or logistical barriers e.g. reduced Medicare privileges with access only to acute services.

Specific patient cohorts will be dependent on local service area need and should be identified in the *Pre-implementation Reflection Tool*. Benchmarking data with key referrers is also available in the *Current State Analysis Report*.

Core elements

Care is typically delivered in a “shared care” or “parallel care” model, in which the acute therapy team act as the primary treating team and the in-reach physicians provide additional rehabilitation specific input. Delivery of rehabilitation is dependent on the unique needs of the individual it may include therapy sessions are provided entirely by the in-reach service or as an adjunct to the acute allied health team rehabilitation sessions (e.g. alternating days or sessions). Prescriptive KPIs regarding intensity or frequency are typically not reflective of the unique needs of various patient cohorts. As such, therapy intensity should be in accordance with patient’s rehabilitation goals, function, and participation ability. In-reach rehabilitation staff should also support to build specialist rehab capability with acute therapists to further service development across the health service.

Clearly defined roles are encouraged to ensure clarity between teams. Exact duties should be defined based on the needs of the individual health service. Medically, it is expected that the acute medical team maintain primary care of the patient, with the rehab medical staff acting as a consultative service to provide support and recommendations as appropriate. For allied health staff, the following task allocation is recommended but not required:

- primary treating acute team: Discharge decisions, escalation of acute medical concerns, injury management and risk prevention (e.g. splinting, casting).
- in-reach rehab team: goal-based rehab intervention, ongoing rehab recommendations.

NDIS applications/documentations, equipment prescription

Local consideration should be made on whether these tasks fit within the duties of the in-reach service or the acute team. It is recommended that this is agreed prior to commencing clinical care to ensure there is understanding between all teams on their roles and expectations.

Establishing local service model

When establishing the local service model, it is encouraged to establish a stakeholder working group with key members of both rehabilitation and acute services to ensure all parties are agreeable to shared care duties to maintain effective relationships between teams. An example of potential shared care duties has been outlined in Appendix 1.

Workflow processes

Referrals/admission

Referral and admission processes for in-reach rehabilitation services should be designed to ensure timely identification, assessment, and transfer of suitable patients. Key considerations include:

- referrals may be made from the acute or surgical care team depending on local workflow and workforce considerations. Logistics will be dependent on local processes for typical rehab referrals. These may include paper-based forms, electronic forms, referrals via electronic medical records, or phone call referrals.
- mechanisms of referrals may also include:
  - automated or blanket referral processes for selected patient cohorts
  - rehabilitation clinician inclusion in case conferencing and ward rounds.
  - use of a screening tool such as the Proactive Rehabilitation Screen to identify appropriate patients (Wu et al, 2025) – Refer to Appendix 2 and Appendix 3 for the PrES tool.
- assessment of suitability of referral by senior rehabilitation clinician e.g. Rehab CNC prior to acceptance and transfer
- eligibility criteria should be reflective of the needs of the individual health service with consideration of service gaps or key admission cohorts. For example, in wards with high acute allied health staffing ratios, in-reach may not be a priority when sufficient therapy intensity is already provided. However, other health services may not have sufficient acute staffing in equivalent wards to meet the rehabilitation needs as intensively and would benefit from in-reach input. Local referral pathways should be established dependent on these needs. Determination of appropriate referral pathways and caseloads can be made through use of the Pre-Implementation Reflection tool (hyperlink) to consider the unique needs of an individual service.
- receipt and management of referrals is typically managed by administration officer, team Leader or senior medical or AHP staff. All referrals should be monitored and captured, though the modality may vary between health services. Example excel spreadsheets have been provided for referral management and current patient management to support data capturing and evaluation (hyperlink). Typically, on receipt of referral, patient's will be assessed for suitability for the service by the in-reach medical team members, CNC or senior AHP staff. Admission processes may vary depending on service size and capacity.

It is recommended that all in-reach services maintain NSQHS standards in delivery of patient care. Specific actions and alignment objectives are available in the NSQHS Alignment resource. Regular case conferences are recommended to ensure holistic MDT oversight of patient admission and provide shared decision-making opportunities.

Discharge

Discharge from the in-reach rehabilitation service should follow a structured process that ensures patients transition safely and appropriately to the next stage of their care. Key considerations include:

- discharge criteria and processes from the in-reach setting will depend on the local service model, patient rehabilitation goal attainment and any ongoing rehabilitation or medical needs.
- patient may be discharged or stepped-down from the in-reach setting based on ongoing rehabilitation needs (e.g. inpatient rehabilitation, transferred back to the acute care team), or directly home (with or without ongoing rehabilitation care in the community or home-based setting).
- consideration should be made regarding service duration and if a general admission length should be identified, e.g. two weeks. This should also guide expectations for service users. Noting that guidelines may need to be flexible to adjust for the unique needs of individuals, e.g. patients without discharge destinations, who are ineligible for subacute services or specialist sub-acute units with more extensive waitlists.
- it is recommended to complete discharge summaries in keeping with communication standards and local procedures. Additionally, there will be discharge outcome measures required for AROC reporting and local KPIs. Minimum data sets are explored below.

Workforce considerations

The in-reach rehabilitation multidisciplinary team (MDT) should be structured to ensure patients receive coordinated, specialist rehabilitation input within the acute setting. Key considerations include:

- in-reach rehabilitation MDT typically includes a rehabilitation physician, senior rehabilitation nurse/CNC and allied health clinicians. Allied health disciplines included in the core team will vary based on the typical patient cohort at a local level.
- for HHSs without access to rehab physicians, it is recommended to consider alternative AHP or CNC led model of care.
- it is recommended that the governance and management of the in-reach MDT generally sits within the broader rehabilitation service though remains as a separate service to ensure dedicated Full Time Equivalent (FTE) staffing and prevent deployment to alternative services. It is important to note that this may limit in-reach staffing support or backfill in episodes of high leave. Consideration can be made for additional budget allowances for leave cover and backfill, however noting this may be limited by availability of backfill staff.
- the in-reach MDT composition may vary based on patient cohort but should be adaptable to ensure access to full range of disciplines as required. The Pre-Implementation Reflection Tool can be utilised to consider the key patient cohorts and referral pathways to inform workforce composition rationale.
- given the specialist nature of the in-reach Rehabilitation service, it is recommended that team members are recruited with prior experience in rehabilitation or with the local hospital context Experience goes beyond the clinical needs of the service but should also consider knowledge of local referral pathways and key discharge pathways including community follow up options.
- the following staffing guidelines have been established based on AFRM standards (Appendix 4), and benchmarking of existing in-Reach Services across Australia. Noting that the AFRM standards have been established for an inpatient/sub-acute service rather than an in-reach model and varied patient cohorts will impact necessary ratios. Furthermore, while benchmarking provides a necessary basis for staffing guidelines not all existing services are going to be reflective of unique HHSs needs (e.g. rural/remote, small size, high demand for First Nations partnership).

Category definitions

- **Foundational** – Disciplines that are always required to deliver safe, effective baseline care

and meet minimum standards.

- **Condition-specific** – Disciplines engaged based on patient complexity, diagnosis, or specific clinical needs.
- **Supportive** – Disciplines that enhance patient outcomes, experience, and holistic care but are not always required.

Figure 1. Workforce considerations per discipline

Discipline	Category	Comments
Medical	Foundational	**Core contribution**: Provision of specialised rehabilitation medical input to manage holistic, medical management alongside the treating acute team. Oversight of eligibility and suitability of patient referrals and acceptances onto in-reach service. **Capability/seniority/ratio:** Recommended at a minimum, part-time oversight of SMO/Consultant. Full time registrar FTE is recommended to manage daily intakes, discharges and medical monitoring of rehab caseload. For larger services, it is recommended to consider inclusion of a resident to support high degree data management, patient monitoring and reporting.
Nursing	Foundational *	**Core contribution:** The rehabilitation nurse works alongside the medical team for patient assessment, providing rehabilitation recommendations. They also support to build capability of acute care nurses in rehabilitation therapy, ways of promoting patient participation and technical skills. **Capability/seniority/ratio:** Given the specialist rehabilitation skills, it is recommended to have a CNC (NG7). *Some in-reach services utilise general rehab CNCs that may share part duties with subacute rehab services or other areas of the hospital. Typically, only one CNC is required per service though FTE considerations will be dependent on service size and localised nursing capability frameworks. Consideration could be made to utilise a CN (NG6), if adequate clinical expertise in rehabilitation and appropriate clinical supervision or operational supports in place.
Physiotherapy (PT)	Foundational	**Core contribution:** The physiotherapist provides rehabilitation intervention to optimise mobility, strength and physical function, depending on the goals and needs of the patient. **Capability/seniority/ratio:** Given the specialist nature of rehab caseload, it is recommended to have a senior or advanced physiotherapist. It is recommended to maintain a ratio of 1 PT:6-8 patients, depending on acuity/complexity, manual handling requirements (e.g. 2xA) and referral demands.
Occupational Therapy (OT)	Foundational	**Core contribution:** The occupational therapist provides rehabilitation intervention to optimise function and cognition, depending on the goals and needs of the patient. **Capability/seniority/ratio:** Given the specialist nature of rehab caseload, it is recommended to have a senior or advanced AHP Occupational Therapist. It is recommended to maintain a ratio 1 OT: 6-8 patients, depending on acuity/complexity, manual handling requirements (e.g. 2xA) and referral demands.

Discipline	Category	Comments
Allied Health Assistant (AHA)	Foundational	**Core contribution:** Support delivery of rehabilitation programs and facilitates increased or maintained therapy intensity. Support therapists in provision of therapy for patients that require two staff members (e.g. 2xA manual handling or complex behaviours). **Capability/seniority/ratio:** Given the specialist nature of rehab caseload and high degree of self-management, it is recommended to have a senior or advanced AHA (CA4). It is recommended to have a ratio of 1 AHA: 3 AHP staff.
Speech Pathology (SP)	Condition-Specific	**Core contribution**: Providing rehabilitation to conditions with deficits specific to speech and language. **Capability/seniority/ratio:** Specialist rehabilitation speech pathology staffing may not be a priority in hospital services without caseloads with high incidence of these deficits (e.g. neuro/stroke). For services with high volume patient cohorts with speech rehabilitation needs, it is recommended to include one senior speech pathologist. Part-time FTE could be considered for services with infrequent or low volume referrals of cohorts that require speech pathology input.
Social Work (SW)	Supportive	**Core contribution:** Support to manage complex psycho-social needs and family supports. Supporting the MDT to provide enhanced care by providing holistic lens to the team's intervention planning and patient care. **Capability/seniority/ratio:** It can be challenging to delineate rehabilitation specific social work input that differs to the work of the acute social work services so inclusion in the team may not be prioritised in services with sufficient support available from acute Social Work workforce. In the absence of capacity of the acute workforce, it can be considered to include one senior Social Worker within the in-reach workforce.
Psychologist	Condition-Specific	**Core contribution:** Supports cognitive, emotional and behavioural factors influencing rehab for patients and their families. **Capability/seniority/ratio:** Specialist rehabilitation Psychology staffing may not be a priority in hospital services without caseloads with high incidence of mental health deficits, specific to their rehab goals, or with adequate access to alternative mental health supports. For services with high volume patient cohorts with Psychology needs, it is recommended to include one senior Psychologist. Part-time FTE could be considered for services with infrequent or low volume referrals of cohorts that require Psychology input.
Neuropsychologist	Supportive	**Core contribution:** Providing complex neuropsychology assessment and diagnostic clarity to inform rehab intervention and assessment planning. Specialist Neuropsychology is ideal for services with complex neuro caseloads. **Capability/seniority/ratio:** While some clinical psychologists have dual qualifications for neuropsychology, in the event they have singular qualifications, neuropsychology would be supportive for

Discipline	Category	Comments
		enhanced care but may not be required in staffing plans, particularly in services without neuro caseloads.
Dietician	Supportive	**Core contribution:** Addresses nutritional factors impacting recovery and rehabilitation potential including nutrition based assessment and intervention where malnutrition or complex dietary needs impact on rehab outcomes. **Capability/seniority/ratio:** Given minimal specialised rehabilitation scope, Dietician may not be a priority in services with adequate acute staffing however they can contribute to enhanced care by providing holistic lens to the MDT's intervention planning and patient care. If included in workforce, this is likely most suitable in a part time capacity at a senior level.
Admin Officer (AO)	Foundational *	**Core contribution:** Administration of high degree of data management including AROC reporting. In areas without access to AO staffing, administration duties typically are absorbed by junior medical staff or CNC, though in larger services, this is typically unsustainable while maintaining clinical caseload. **Capability/seniority/ratio:** *Consideration could be made to combine FTE of the Team Leader and Admin Officer in smaller services with less administrative/operational demands. Services typically utilise an AO4 during the project development phase of service establishment and often utilising AO3 for business-as-usual workforce.
Team Leader (TL)	Foundational *	**Core contribution:** Manage high level of operational demands, reporting and leadership. Oversight of patient intake and packages jointly with in-reach medical team. **Capability/seniority/ratio:** Dedicated team leaders typically require a high level of seniority to manage complex operational and clinical leaderships so requires a HP5/NG7. Alternatively, operational/leadership duties can sit with senior medical staff or Advanced AHP, though this is typically unsustainable while maintaining clinical caseload. *Consideration could be made to combine FTE of the Team Leader and Admin Officer in smaller services with less administrative/operational demands.
Aboriginal and Torres Strait Islander/ First Nations Support Officer	Supportive	**Core contribution:** Providing enhanced care and ensuring cultural safety for Aboriginal and Torres Strait Islander in-reach patients. **Capability/seniority/ratio:** No services to date have embedded a support officer within the team, however this could be desirable in HHSs with a high volume of Aboriginal and Torres Strait Islander patients. If dedicated Support Officer is unable to be embedded in in-reach service, it is vital to build connections with First Nations Liaison service or Nurse Navigators to optimise in-reach patient's access to culturally safe care.

All foundational disciplines should be included as a minimum standard; however best practice may be for addition of Condition-Specific and Supportive disciplines depending on the unique clinical

requirements of an HHS. Use of the pre-implementation reflection tool should be utilised to identify these needs and inform which disciplines are required and inform individual staffing plans.

Additional staffing considerations

To maintain workforce sustainability, it is important to consider the impact of planned and unplanned leave on team staffing. Where possible, leave coverage should be embedded into workforce funding, though noting difficulty with access to staff to cover short-term secondments.

Additionally, it is vital that workforce budgets allow for annual changes to staff banding and pay points. Adequate funding will be necessary to staff more senior bands within levels e.g. HP3.7 / NG7.4 depending on the clinical experience of staff, and to allow for their continued progression through banding as per the respective Queensland Health Enterprise Bargaining Agreements.

Outcome measures

It is recommended that all in-reach services in Queensland report to AROC's Pathway 2 in-reach data set to allow for consistent benchmarking of services across the state and allow access to summarised, de-identified information on the outcomes of all in-reach Rehab services. It is recommended that all Queensland in-reach services collect and report on the following minimum data set per patient and as an overall service. The following data sets have been identified based on the required AROC data and the common practice of existing in-reach Rehab Services in benchmarking. The data sets have been categorised as either:

- Baseline: A requirement as a minimum data set for an in-reach service to ensure consistent benchmarking and/or reporting via AROC.
- Supplementary: An optional additional data set to capture further information dependent on the unique needs of an HHS and the key goals that a specific in-reach service is trying to achieve.

Figure 2. AROC Patient level data set

Data Set	Category	Comments
Patient demographics (URN, Full Name, Sex, DOB, Age, Indigenous Status, Language Spoken, Address/Contact details)	Baseline	AROC Minimum Data Set requirement
AROC Impairment Code	Baseline	AROC Minimum Data Set requirement
Pre-existing Comorbidities / PMHx	Baseline	AROC Minimum Data Set requirement
Date of admission	Baseline	AROC Minimum Data Set requirement
Functional Independence Measure – Admission	Baseline	AROC Minimum Data Set requirement
Functional Independence Measure – Discharge	Baseline	AROC Minimum Data Set requirement

Data Set	Category	Comments
Discharge Destination / Accommodation status post discharge	Baseline	AROC Minimum Data Set requirement
In-reach Length of Stay	Baseline	AROC Minimum Data Set requirement.
Patient Reported Outcome Measure (PROM)	Supplementary	Can be captured using a new or existing PROM – nil currently available on Queensland Health Online PREM/PROM system.
Patient Reported Experience Measure (PREM)	Supplementary	Can be captured using a new or existing PREM – nil currently available on Queensland Health Online PREM/PROM system. Can utilise the Australian Modified Client-Centred Rehabilitation Questionnaire via AROC. They can be emailed directly for resources or the survey can be completed here.
De Morten Mobility Index (DEMMI)	Supplementary	Existing in-reach services utilise this measure to capture mobility and gait-based changes with more detail than the FIM.
Modified Iowa Level of Assistance (mILOA)	Supplementary	Existing in-reach services utilise this measure to capture mobility and gait-based changes with more detail than the FIM.
Functional Ambulatory Classification (FAC)	Supplementary	Existing in-reach services utilise this measure as a fast, clear alternative measure of walking independence and required assistance

Figure 3. Service level data set

Data Set	Category	Comments
Average FIM efficiency	Baseline	AROC Minimum Data Set requirement.
Average FIM change	Baseline	AROC Minimum Data Set requirement.
Number of in-reach rehabilitation referrals received	Baseline	This data is vital to demands on the service will likely inform regular reporting through program sponsors or executives.
Number of in-reach rehabilitation referrals declined and key reasons for non-acceptance	Baseline	This data is vital to capture suitability of referrals and acceptance rate and will likely inform regular reporting through program sponsors or executives.

Data Set	Category	Comments
Days from in reach rehabilitation referral to acceptance	Baseline	This data informs the demands of the service and captures efficiency of the service in assessment of patients following referrals and will likely inform regular reporting through program sponsors or executives.
Days from referral acceptance to rehabilitation admission (start delays)	Baseline	This data informs the demands of the service and captures efficiency of the service in patient turnover and will likely inform regular reporting through program sponsors or executives.
In-reach rehabilitation length of stay	Baseline	This data set is key in identifying efficiency of the service in patient turn-over, in addition to effectiveness in patient flow outcomes. This data set can be benchmarked using the AROC AN-SNAP calculator and inform the bed days saved.
Number of patients transferred to an inpatient rehabilitation service	Baseline	Necessary to identify the number of patients continuing to require rehabilitation and impacts on subacute facilities.
Number of patients transferred directly home	Baseline	Captures the number of patients that have avoided subacute admission and key data set for identifying bed days saved.
Number of patients transferred to step-down bed	Supplementary	Key in identifying patient flow pathways within the HHS, however, may not be relevant in smaller services without available step-down beds.
Bed days saved in avoided admissions to inpatient rehabilitation and return on investment	Supplementary	This can be calculated for patients discharged home using the AROC AN-SNAP calculator to identify the projected length of stay per impairment code, compared with actual length of stay on the in-reach program.
Hospital Acquired Complication	Supplementary	Complication can be calculated depending on typically collected complication data for health services – refer to CEQ HAC data document.
Complexity Data	Supplementary	Complexities that are unique to health service e.g. 2xA, MRO/Isolation, Bariatric, NWB, Nurse Special/1:1, Tracheostomy, Secure/Prisoners, Out-of-catchment patients. Specific complexities may be identified by local health service to capture the unique caseloads for that HHS.

Benefits and risks to implementation

Benefits

Implementing an in-reach rehabilitation model offers a range of potential benefits for patients, staff, and the broader health service. Key benefits include:

- improved patient functional outcomes and reduced risk of hospital acquired complications and deconditioning because of earlier rehabilitation intervention.
- improved patient flow through both the acute and sub-acute care settings, including:
    - Reduced length of stay in the acute care environment
    - Ability to discharge some patients directly home and avoid inpatient rehabilitation admission
    - Reduced length of stay in the inpatient rehabilitation setting.
- opportunity to provide patients with uncertain rehabilitation tolerance a “trial of rehabilitation” prior to transfer to inpatient rehabilitation thereby minimising the risk of inappropriate transfer.
- building capability of acute care clinicians in rehabilitation care.
- early identification and proactive management of potential barriers to discharge planning such as aged care and NDIS.
- provision of patient and carer education and expectations for participation in rehabilitation.

Risks

While an in-reach rehabilitation model offers significant benefits, there are also potential risks and challenges that health services should consider and proactively plan for, including:

- misalignment in leadership and/or decision-making processes between acute care and rehabilitation teams due to teams working independently.
- lack of appropriate resourcing to in-reach team to enable access to full MDT and required level of intensity of therapy.
- reduced access to adequate therapy or treatment spaces in acute setting.
- reduced access to adequate space for equipment and supplies including consumables.

Case study

Service model

Gold Coast Hospital and Health Services operates an in-reach rehabilitation model of care under the name Rehabilitation Response Team (RRT). This service is managed operationally under the Division of Medicine under the Rehabilitation, Aged Care & Community Services (RACCS) stream. The Rehabilitation Response Team operates across Gold Coast University Hospital and Robina Hospital. At GCUH, the service is structured into three sub-teams, while Robina functions as a single team. Senior Allied Health Clinicians (HP4) coordinate patient allocation within physiotherapy- and occupational therapy-led streams, with overlay input from speech pathology, psychology, and social work based on clinical need (varying by site). This model determines the patient’s rehabilitation consultant oversight and treating allied health team, ensuring coordinated multidisciplinary care across both campuses.

The RRT provides intensive rehabilitation services to patients on the acute wards, under acute physicians. If suitable under the AN-SNAP guidelines and local procedures, the service will aim to ensure patients are under a rehabilitation episode of care.

Background

The RRT was established in 2016 in response to closures in sub-acute rehabilitation beds within Gold Coast Health, requiring alternative access to rehabilitation services. Following initial success of the program, they obtained permanent funding and later, an uplift in their services to 16 packages followed by an additional uplift to 20 packages more recently.

Since their inception, they have also expanded to include an additional RRT team at Robina Hospital within another hospital within the same health district. They are both permanently funded.

Patient cohort

RRT typically holds a caseload of 20 patients at GCUH and 8 patients at Robina Hospital. These patients are received from all acute wards across the hospital including mental health. They are accepting of all patients that are considered to require rehabilitation with no set inclusion criteria given the varying clinical areas. All patients will have a clinical objective bed-side assessment of rehabilitation needs and reading to begin rehab. This includes patients with the following:

- Out of catchment area
- Adolescence
- Telemetry**
- Tracheostomy
- High Flow Oxygen**
- TPN
- Drains**
- 1:1 Nursing (Special)
- Problematic behaviour
- Lack of engagement
- Mental health inpatient
- Uncertain rehabilitation benefit/prognosis
- Discharge destination

** Indication requires consideration

Referral pathways

All referrals to the rehabilitation services at GCUH are completed on one centralised referral form that is emailed on completion. Once referrals are received, a suitability assessment is completed to determine if patients are appropriate for RRT or inpatient rehabilitation and waitlisted or declined accordingly. Once a package is available on the RRT service, senior allied health clinicians

will allocate patients to an appropriate team depending on clinical suitability and caseload capacity. Once allocated, their package is initiated.

Referrals are received from a variety of areas. Referrers include:

- Medicine and subspecialities
- Surgery
- ICU and Trauma
- Paediatrics
- Mental Health inpatients.

Blanket referrals are also received for key referrers including:

- Major trauma or trauma with complexity
- Stroke
- Post hip fracture surgery

Service provision

The service operates under a shared care model with acute teams. This includes shared medical care with RRT providing consultation to optimise medical status to maximise benefit from rehabilitation and functional recovery. The allied health teams maintained shared care by completing the following:

- early discussions and input from acute therapy teams into shared care guidelines for each AH discipline.
- communication – daily handover with acute, daily ieMR entry
- collaborative treatment planning and scheduling with acute multidisciplinary team
- case conference – twice weekly. Each patient discussed once weekly.
- case management
- patient led goal setting
- stakeholder meeting attendance
- family meeting attendance
- discharge and community follow-up recommendations.

Workforce

The current team at GCUH and Robina consists of:

- 2 x FTE Rehabilitation Physician (0.9 FTE total)
- 2 x HP4 Occupational Therapist (1.0 FTE)
- 2 x HP4 Physiotherapist (1.0 FTE)
- 3 x HP3 Occupational Therapist (2.0 FTE)
- 3 x HP3 Physiotherapist (2.0 FTE)

- 1 x CA4 OTA (1.0 FTE)
- 3 x CA3 (AHA) (3.0 FTE)
- 1 x HP4 Speech pathologist (0.5 FTE)
- 2 x Clinical Psychologists
- AO3 (1.5 FTE)
- 1 x Team Leader (HP5/NG7) (1.0 FTE)

Patient example

A 73-year-old woman residing in a residential aged care facility (RACF) clearly demonstrates the breadth of the in-reach rehabilitation team's scope, reach, and potential for positive functional outcomes. The patient was admitted to an inpatient mental health unit with psychotic depression and catatonic features. While she remained on the acute mental health unit, she was referred to and accepted by RRT.

Prior to admission, the patient was independent with mobility with a single-point-stick (SPS) or a four-wheeled walker (4WW) and was able to complete all self-cares independently. At the time of acceptance onto the RRT program, the patient required a full hoist with two-person assistance for transfers, although she was able to complete a Sara Stedy transfer during physiotherapy sessions.

She mobilised only via wheelchair to mobilise with the propel assistance and required assistance for all personal care activities and presented with impaired recall and impulsive behaviours.

Her rehabilitation goals included:

1. Independence/ stand-by assistance with mobility with SPS/4WW for short distances
2. Independence with toileting
3. Independence with dressing upper and lower body
4. Independence with showering

Over 16 days on the RRT program, the patient demonstrated marked improvement. She was subsequently transferred to the inpatient rehabilitation ward at GCUH. At the time of her RRT discharge, she was mobilising with a four-wheel walker with standby assistance and completing ADLs with minimal or set-up assistance.

RRT was able to provide early access to intensive rehabilitation services while receiving treatment in the acute mental health unit. The team also advocated and provided evidence for her rehabilitation potential, supporting her transition to the inpatient rehabilitation unit. Following completion of her rehabilitation program at the inpatient unit, the patient was able to return to her usual RACF with substantially improved functional independence and overall quality of life.

Appendices

Appendix 1

It is important to identify and clarify the roles and responsibilities of the in-reach rehabilitation service and acute therapy team at the inception of the model of care, with endorsement from the acute service. This ensures shared understanding and agreement between services for collaborative care of the patient. However, these task allocations should not be overly rigid; flexibility must be maintained to adapt to variations in skill mix, patient complexity, and clinical demands. The following is an example of potential distribution of duties; however, this is not prescriptive and can be adapted to individual services.

Discipline	In-reach rehab team responsibilities	Acute teams responsibilities
Medical	Provides rehabilitation-focused medical oversight to offer consultation/support for the primary treating medical team.	Leads acute medical management and maintains primary patient care including ongoing referrals.
Nursing	Delivers rehab-oriented nursing care, supports functional independence, and coordinates patient flow within in-reach service.	Maintains usual acute, ward-based nursing cares.
Occupational Therapy / Physiotherapy	Provides increased therapy intensity with rehab specific, goal-based rehab assessment and interventions. This may include: OT: Functional retraining, upper limb or cognitive rehabilitation. PT: Mobility and strength training, gait retraining, and prevents deconditioning.	Provision of standard acute therapy activities including oversight of function and goals. Manages acute risk and discharge planning. Typically, discharge planning includes equipment prescription and NDIS/funding applications or documentation.
Speech Pathology	Focuses on rehabilitation specific, goal-based assessment and interventions. This may include language, cognitive communication, motor speech, voice and/or swallow domains. Communication assessment may be completed where further information is required to define impairment and guide intervention.	Conducts swallowing assessments and risk management. Oversees acute communication needs including administering initial communication screener/assessment as and when appropriate.
Dietetics	Develops nutrition plans for rehab phase, supports long-term dietary needs.	Manages acute nutritional risks and ensures safe feeding strategies.

Discipline	In-reach rehab team responsibilities	Acute teams responsibilities
Social Work	Coordinates psychosocial support, community linkage, and discharge planning.	Addresses immediate social risks and supports family during acute admission.
Psychology	Provides cognitive and emotional rehabilitation strategies, supports adjustment to disability.	Offers acute psychological support for distress or crisis situations.

Appendix 2

Original PReS Tool (Wu et al., 2025)

Care Needs (current)

0	Largely independent
1	Requires help from 1 person
3	Requires help from at least 2 people (and/or 1:1 supervision)

Equipment needs (Current)

0	No equipment needs	
1	Basic equipment	(mobility aid, wheelchair, non-customised orthotic, brace, walking belt, pressure care equipment)
2	Highly specialised equipment	(limb prosthesis, hoist, customised wheelchair or orthotic, communication aid, tracheostomy, bariatric equipment)

Therapy disciplines involved (last 5 days) ***[tick all involved]***

0	0 disciplines
1	1 discipline
2	2-3 disciplines
3	4-5 disciplines
4	>5 disciplines

	Physiotherapy		Dietician
	Occupational therapy		Liaison psychiatry or psychology
	Social work		Prosthetist, Orthotist
	Speech pathology		Stomal therapist
	Other (e.g. cultural liaison officer, care coordinator)		

Therapy Intensity (last 5 days)

0	No therapy (0 or 1 session)
1	Low – less than daily (< 5 sessions)
2	Moderate – daily therapy (5+ sessions)
3	High – 2 assist required for therapy sessions & <10 sessions
4	Very high – 2 therapy sessions per day (i.e. 10+ sessions)

Other

1	Pre-existing physical or cognitive disability
1	Medically stable and ready for transfer to subacute rehabilitation

Total Score: _____ / 15

Outcome: _____ RULE IN _____ RE-SCREEN in 1-week _____ RULE OUT

Appendix 3

Modified PReS tool with new scoring system.

Domain		Score
Age (years)	≥ 65	2
	< 65	0
Allied health sessions in preceding 5 days	≥ 5	2
	< 5	0
Assist to mobilise	2 or more assist	3
	other	0
New impairment in personal care (showering or toileting)	Yes	9
	No	0
Medically ready for discharge but functionally unable to be discharged (discharge barriers)	Yes	4
	No	0

(Wu et al., 2026)

Appendix 4

(Royal Australasian College of Physicians, 2019)

Allied Health and Other Professional Staff

Table 1 Allied Health Staff to Patient Ratios for each 10 Inpatients

Impairment Type	Occupational Therapist	Physio-Therapist	Allied Health Assistant	Speech Pathologist	Clinical Psychologist	Neuro- Psychologist	Social Work	Dietitian
Amputation	1	1.5	0.5	consult[1]	0.5	consult[1]	0.6	0.4
Stroke / Neurology	1.5	1.5	0.5	1.5	0.5	0.5	1.0	0.5
Orthopaedic	0.8	1.25	0.5	0.1	0.2	consult[1]	0.5	0.4
Major Trauma[2]	1.2	1.5	0.5	0.2	0.4	0.5	1.0	0.6
Spinal Cord Dysfunction[2]	2	2	0.5	0.25	0.5	0.3	1.2	0.4
Traumatic Brain Injury[2]	1.5	1.5	0.5	1.5	0.8	0.8	1.2	0.5
Reconditioning and Restorative	1.2	1.25	0.5	0.2	0.4	0.2	1.0	0.5

Notes:

a. This table provides indicative of staffing levels for a five day per week rehabilitation program. A six or seven day per week program requires additional staffing. Refer to 2.1.26

b. The staffing levels outlined in this document do not include staffing sufficient to relieve staff who are on leave.

c. The staffing levels do not include time required for teaching and research activities.

d. [1]'consult' denotes the availability of staff on a consultation basis, as required.

e. [2] Major Trauma is defined as complex injuries to multiple body systems that may also include spinal cord dysfunction and/or traumatic brain injury (TBI).

f. Prosthetist / Orthotist: See section 2.1.33 and 2.1.34

References

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