NSQHS standards alignment resource

The *In-reach rehabilitation model of care* (MOC) provides early, multidisciplinary rehabilitation within acute care settings. It enables delivery of goal-directed therapy by a specialist rehabilitation team on acute wards in collaboration with the treating team. This guide describes how an In-reach MOC supports the National Safety and Quality Health Service (NSQHS) Standards and provides practical examples, processes, and measures to demonstrate compliance across the standards.

NSQHS Standard	In-reach Strategies	Evidence & Measures	Detailed Examples
Clinical governance	• Establish clear shared-care governance with defined roles between acute and rehabilitation teams • Credentialing and scope of practice for medical, nursing, and allied health staff • Organisation-wide incident reporting and open disclosure; integrate In-reach data • Routine quality reporting: Australasian Rehabilitation Outcomes Centre (AROC) Pathway 2 dataset	• Incident/complaint themes and action logs with trend analysis • Audit of credentialing currency and performance review completion • AROC pathway 2 reporting for data management/credentialing	• Establish a joint Acute–Rehab Governance Group that reviews monthly safety reports and resolves role clarity issues • Use Pre-Implementation Reflection to define local referral pathways and caseloads and ensure appropriate escalation pathways dependent on clinical needs • Embed open disclosure procedures for therapy-related incidents
Partnering with consumers	• Embed shared decision-making and goal setting with patients/carers • Use culturally safe practices; partner with First Nations liaison services or embed within service staffing • Provide tailored education materials on participation in rehab and discharge plans	• Patient Reported Experience Measures (PREM)/ Patient Reported Outcome Measure (PROM) collection • Audit of documented shared decisions and consent • Audit of goal setting practices and consumer involvement • Diversity representation in consumer partnership activities	• Use a Goal Attainment Scaling (GAS) or Patient Specified Functional Scale (PSFS) jointly completed with the patient/carer • Invite consumer representatives or input for In-reach service evaluations or strategic planning • Translate resources and use interpreters where needed

Preventing and controlling Infections	• Apply standard/transmission-based precautions within acute wards • Fit-testing and training for Personal Protective Equipment (PPE) PPE; audit compliance • Safe reprocessing/cleaning of therapy equipment	• Hand Hygiene Initiative reporting; environmental cleaning audits • Device-related infection surveillance; PPE training completion rates • Documentation of transmission-based precautions in care plans	• Dedicated therapy kits for isolation rooms; single-patient equipment where feasible • Alternate delivery methods to reduce aerosolisation risks • Joint ward rounds with infection prevention team for complex patients
Medication safety	• Best possible medication history and reconciliation at referral/acceptance • Document adverse drug reactions and therapy-related changes	• Documentation audits for key patient cohorts with high-risk medication management	• Standardised communication of pain management regimens and bowel care plans relevant to therapy participation
Comprehensive care	• Integrated screening and assessment (falls, pressure injury, cognition, nutrition) • Individualised rehabilitation plan with early discharge planning	• Falls and pressure injury incidence, skin inspection compliance • FIM change and efficiency, discharge destination tracking	• Use of comprehensive patient outcome measures to ensure adequate screening for above complications • Cognitive screening with delirium pathway; implement non-pharmacologic delirium prevention bundle
Communicating for safety	• Structured clinical handover (ISBAR) between teams and at transitions • Use three identifiers for patient and procedure matching • Documentation of alerts, risks, progress	• Handover audit compliance; timeliness of discharge summaries • Documentation completeness audits; consumer-reported comprehension of plans	• Weekly case conferences • Shared digital care plan accessible to both acute and rehab teams • Bedside whiteboards with agreed goals +/- daily therapy schedule

Blood management	• Monitor post-operative anaemia impacting rehab	• Anaemia prevalence in rehab cohort.	• Rehab readiness protocols include haemoglobin thresholds and fatigue management plans
Recognising and responding to acute deterioration	• Individualised monitoring plans; observe for mental state changes and delirium • Escalation criteria and rapid response access during therapy sessions	• Time-to-escalation metrics; MET call activation reviews • Documentation of reassessment and changes in care plans following deterioration • Audit of RISKMAN and MET call incident reports	• Therapist-initiated MET call protocol training and drills • Use clinical deterioration badges/cards and escalation posters in therapy areas • Rapid referral pathways to mental health and definitive management services