Central Adelaide Local Health Network
Rehabilitation In The Home (RITH)

Overview:
RITH is a home-based rehabilitation service that aims to assist people to achieve their best level of independence through early supported discharge from hospital. Rather than stay in an acute setting (or hospital ward), patients can return home and receive equivalent inpatient rehabilitation services in their own surroundings, with the support of their usual family and community networks. There is no cost to the patient for RITH.

Rehabilitation involves training and relearning for people to acquire the strength and skills needed to achieve their goals. RITH aims to give its patients the help and information needed to maximise their recovery by the time they finish with the service, and to maintain the best health they can in the future. RITH considers all aspects of wellbeing: physical, psychological, social and financial. The patient, their family and carers are all important members of the rehabilitation team.

Services provided:
RITH offers a range of services including:

> Comprehensive assessment by an inter-disciplinary team
> AH and Nursing services provided over 7 days
> Regular visits from rehabilitation staff including occupational therapy, physiotherapy, speech pathology, nursing, dietetics, social work, allied health assistants and exercise physiology
> Access to psychology and neuropsychology if required
> Provision of information about the client’s condition and about how they can maximise their recovery
> Provision of exercises and rehabilitation equipment to assist recovery
> Personal care training, if required, to help patients regain their independence
> A rehabilitation medical consultant and RMO are available for medical assessment and intervention if required
> Referrals to other services for ongoing input after discharge from RITH
> As a guide, services are usually run from 1-3 weeks in total but this is dependent on how quickly the clients are able to achieve their rehabilitation goals. The approximate length of the client’s stay is also guided by AN-SNAP- that considers the client's functional ability and diagnosis.
Referral and Triage Process:

The Access and Triage Team comprises RN3 CPC Nurses who are available Monday to Friday.

Patients will be seen within 24 hours of referral, excluding weekends. The majority of assessments will be completed and triaged by the Nursing staff, but, when indicated or clinically complex, Consultant/Registrar and allied health may be asked to assist.

If assessment required: Fax/Email the referral to the CARS Triage Team
(Rehab Service will confirm receipt of written referrals with referring ward)

Referral received by the CARS Triage Team for

Rehabilitation In The Home (RITH)
(27 beds)

Triage Team member will visit ward to assess the patient

Findings of the assessment will be documented in the patient file & communicated to ward staff

Follow up reviews of the patient’s status will occur as required

Triage Decision

If appropriate for rehab program, the Triage Team will arrange when a bed is available (inpatient or RITH)*

If eligibility for a rehab program is uncertain, a request for a rehab medical consult will be arranged by the Triage Nurse

If criteria not met for a rehab program, the Triage Nurse will suggest alternative services & can be available to discuss with the patient and/or family if required

A patient can be re-referred if his/her condition improves, making rehabilitation more feasible

*if accepted onto the program please ensure the patient is not discharged home prior to the RITH team being informed
Rehabilitation In The Home (RITH) Referral Criteria

> Patient and/or carer consent
> The patient requires short-term, goal-specific rehabilitation
> Patient requires light assistance for mobilisation
> Patient has a carer available or sufficient social supports
> Patient is continent, or if incontinent this is well managed
> The patient has a home suitable for therapy
> Has a telephone/mobile
> Resides within the Central Adelaide Local Health Network
> Agrees to readmission should complications occur
> Have a definitive diagnosis and be medically stable
> Show the potential to benefit from a rehabilitation program
> Have the physical capacity to participate in an intensive program provided by an interdisciplinary team
> Have the ability to contribute to weight bearing transfers
> Adequate cognitive function for new learning
> Documentation of special considerations e.g. If the patient’s weight is over 120kgs, then special equipment to provide care will require specific planning

For more information

RITH Ph 8222 8659 or 8222 8660
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