START

Supported Transfer and Accelerated Rehabilitation Team

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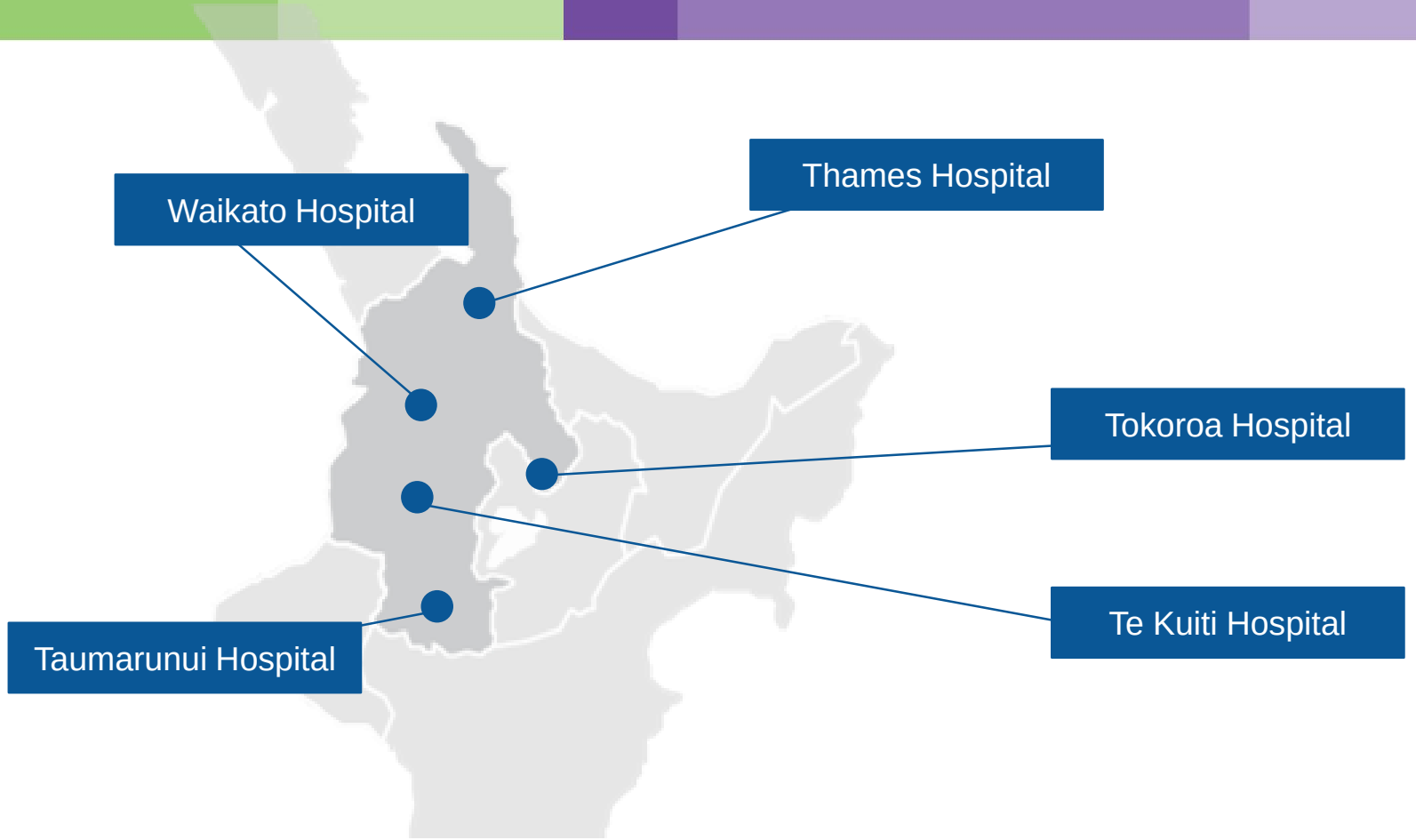
So what is START?

Community-based, **intensive** rehabilitation program for the over 65 year old (except stroke)

With the service for up to 6 weeks (usually 4 weeks)

Provides an interdisciplinary approach with a team of:

Health Care Assistants
Physiotherapists
Registered Nurses
Occupational Therapists
Geriatrician
Administrator


Waikato Hospital
Thames Hospital
Tokoroa Hospital
Te Kuiti Hospital
Taumarunui Hospital

Criteria

- Domicile in the Waikato DHB area
- Discharged from a Waikato DHB hospital or ED
- 65 years and over (or under 65 if stroke)
- An acute illness
- Reduced level of function
- Potential for partial or complete recovery
- Home safe for rehabilitation
- Can transfer safely and doesn’t require assistance nocte
- Rehab goals and agree to participate
- Service needs not covered under another funding stream
- Doesn’t have a progressive disease or palliative
- Not been discharged from hospital for more than 48 hrs

Service Delivery Models

The aim of START is to:

- support earlier discharges
- prevent hospital admissions (ED)
- prevent readmissions

Service Delivery Models

Hamilton Team - 62 patients

Cambridge Team - 40 patients

Thames Team - 25 patients

Tokoroa - 10 patients

Taumarunui - 10 patients

What can START provide?

- 7 day a week service
- Hours 0700hrs – 2100hrs
- RN's available (on duty/on call) 0700-2100hrs
- Up to 4 visits a day
- Programme is developed with the **PATIENT** and the input of all health disciplines
- Goals are based on:

'**What is important to you?**'

Discharge

- InterRAI assessed
- GP discharge letter
- Reinstate existing or new/additional supports with DSL (NASC), ACC, Acute Home Support
- Aged residential care
- No services
- Referred on for on going therapy

Types of Rehabilitation

- Meal preparation
- Personal care
- Housework
- Shopping
- Medication oversight
- Exercise (strength, balance, upper limb, endurance, breathing and individual plans)
- Cognitive exercises
- Speech language exercises
- Self management (catheter care, BGL/insulin, daily weighs, COPD)
- Socialisation
- Transport

The Role of the START Health Care Assistant

An IDT Approach

Case Study 1: Mr J

- Mr J 64 year old, fit, well, lives with wife, still working
- Stroke: Basilar thrombus. Successful thrombolysis and clot retrieval. Ongoing ataxia requiring assist x 2, dysarthria and expressive aphasia.
- Into Hospital level care
- For 6 months
- Wanted to return home – Referred to START from DSL (NASC)

Case Study 1

What is important?

- To communicate well, to be as independent as possible.

What is important whilst with START	Aimed completion date	Outcome: Achieved/ Not achieved	Sign/ date
Mr J will shower independently		A	
Mr J will improve his mobility		A	
Mr J will make his lunch daily		A	
Mr J will improve his communication		A	

Case Study 1

Alerts:
Needs fluids thickened, soft foods
No weekend visits
AM visit to be around 10 AM
PM visit to be around 2 PM

	Goal: Hygiene
Task	Healthcare assistant to assist with shower on Monday, Tuesday, Wednesday, Thursday, and Friday and to assist with dressing. To tidy the bathroom afterwards
Task	For Occupational Therapist review of safety and independence in shower
	Goal: Exercise
Task	Healthcare assistant to coach/supervise exercises daily
Task	Physiotherapist to review, advise on aids and amend exercises as needed
	Goal: Meals
Task	Healthcare assistant to assist client to make lunch at their morning visit
Task	Healthcare assistant to assist client to make hot drink (with thickener) at their morning visit
Task	Occupational Therapist to conduct kitchen assessment and recommend appropriate strategies
	Goal: Cognition/memory/speech
Task	Occupational Therapist to conduct appropriate cognitive assessments and develop, review and update cognitive training programmes as appropriate
Task	Healthcare assistant to supervise speech-language exercises as prescribed by ward or outpatient Speech Language Therapist

Case Study 2 Mrs N

- Mrs B is a lady who lives alone in Cambridge, usually independent.
- Mrs B had a stroke, ended up with an IDC, poor balance, cognitive decline
- When assessed in hospital walk assistance of 1 with a Zimmer frame
- She was rest home level of care, but wanted to try home.

Case Study 2

- Nephew stayed for a week until she was independently mobile

- START 4 times per day for:
    - Personal cares
    - Medication oversight
    - IDC cares (including emptying)
    - Meal prep (and fluids)
    - Exercises

Case Study 2

- Independently dressing and undressing
- Simple meal prep and MOW
- Mobilising with a stick
- IDC out (and assessed for long term pad supply)
- Discharged with 3 showers per week, and home help

Questions