He Kaupare. He Manaaki.
He Whakaora.
prevention. care. recovery.

Patient scenarios for Non-Acute Rehabilitation Pathway (NARP) services

NARP enables districts to move patients between services and settings to match their need. The client remains the responsibility of the district until they exit the NARP services.

The following scenarios show four typical pathways for patients through the NARP service from acute admission to discharge.

Scenario one: Vijay – Inpatient and Community Rehabilitation Pathway

Vijay is an 83-year-old who sustained had a fractured neck of femur after falling off a ladder. He lives at home with his wife and is usually fully independent.

After his accident Vijay presented to ED and was admitted to the orthopaedics ward. Vijay had surgery to address his fracture.

After surgery, Vijay needed a two-person assist to transfer with a walking frame and assistance with personal care. Vijay's clinical team decided he would benefit from a period of rehabilitation and that he met eligibility criteria for NARP services. Vijay accessed inpatient rehabilitation as well as community rehabilitation through NARP services.

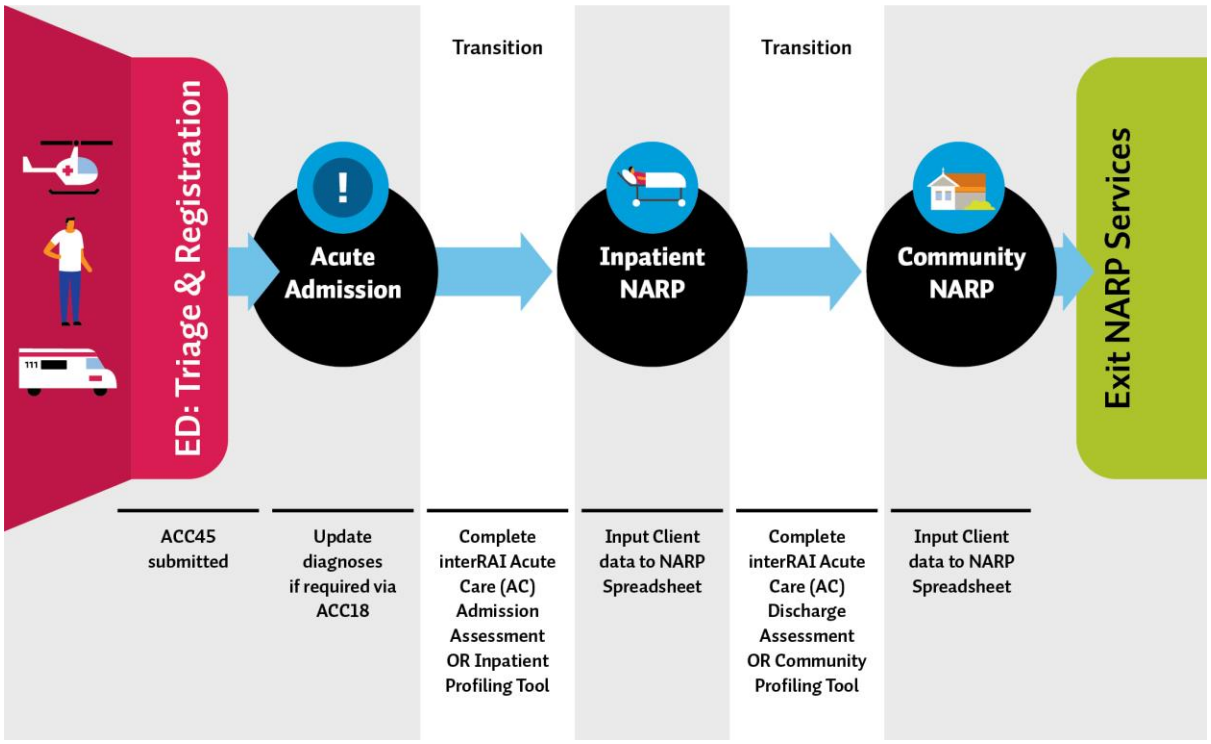

Figure 1: Inpatient and Community Rehabilitation Pathway

Scenario two: Talita – Rehabilitation Admission Avoidance Pathway

Talita is a 75-year-old who fractured her left neck of humerus after she fell while gardening. She lives at home alone and is usually independent with all activities of daily living.

After her accident, Talita presented to ED and was admitted to the orthopaedics ward. She didn't need surgery, was treated conservatively and given a sling to wear. While Talita could walk independently for short distances and needed assistance with personal care and getting out and about in the community.

Talita met eligibility criteria for NARP services. Her clinical team decided that, with the support of a multidisciplinary community rehabilitation team, Talita could safely return home and finish her rehabilitation in the community without needing inpatient care.

In this scenario, the clinical team decided to use the Rehabilitation Admission Avoidance pathway. Talita is then able to access NARP Group 4 Rehabilitation Admission Avoidance services.

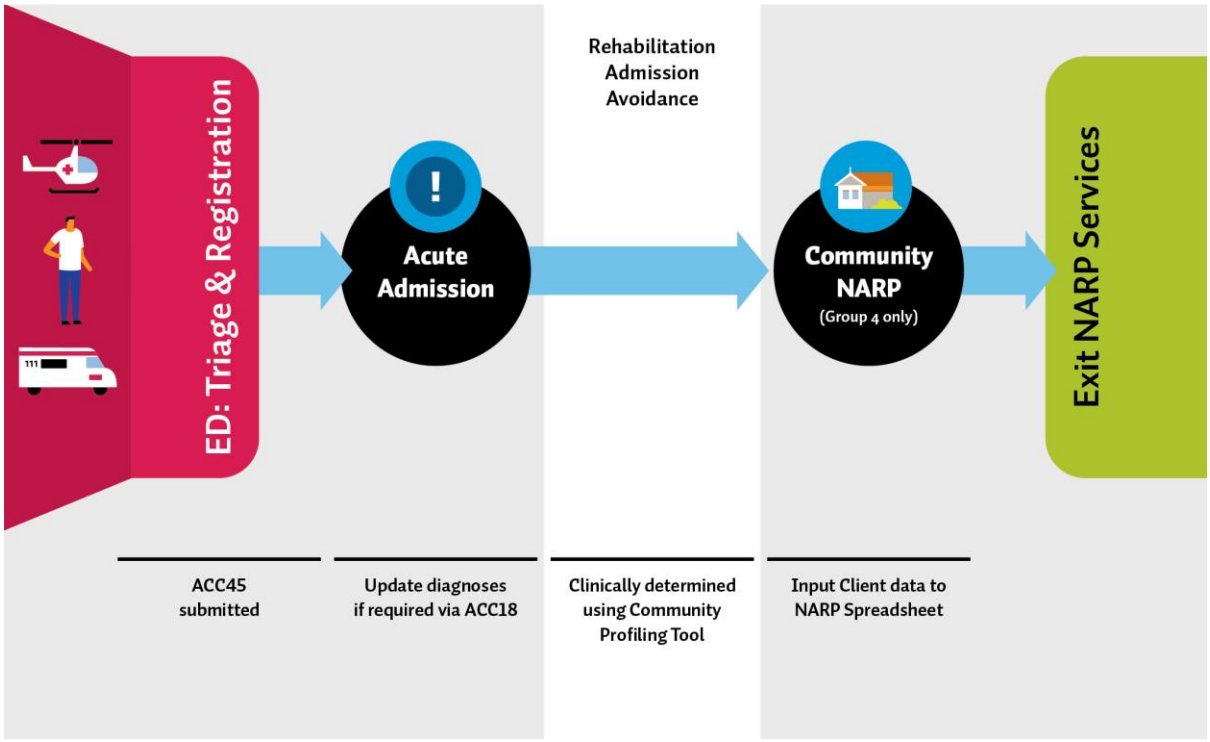

Figure 2: Rehabilitation Admission Avoidance Pathway

Scenario three: Wiremu – Transitional, Inpatient and Community Pathway

Wiremu is an 81-year-old who fractured his right neck of femur after a fall while walking on the beach. He usually lives at home with his wife and is independent with a walking stick.

After his accident, Wiremu presented to ED and was admitted to the orthopaedic ward. Wiremu had surgery and was required to be non-weightbearing for six weeks. He was able to transfer with a walking frame and assistance of one and needed assistance with all personal cares.

Wiremu's clinical team decided he would benefit from some time in transitional care and used the community profiling tool to determine the case mix. He met the eligibility criteria for NARP services.

After six weeks of transitional care, the clinical team determined that Wiremu needed inpatient rehabilitation. The inpatient profiling tool was used on admission to inpatients. Following this, the clinical team then determined that Wiremu needed a period of community rehabilitation, and the community profiling tool was used for the second time in Wiremu's NARP journey.

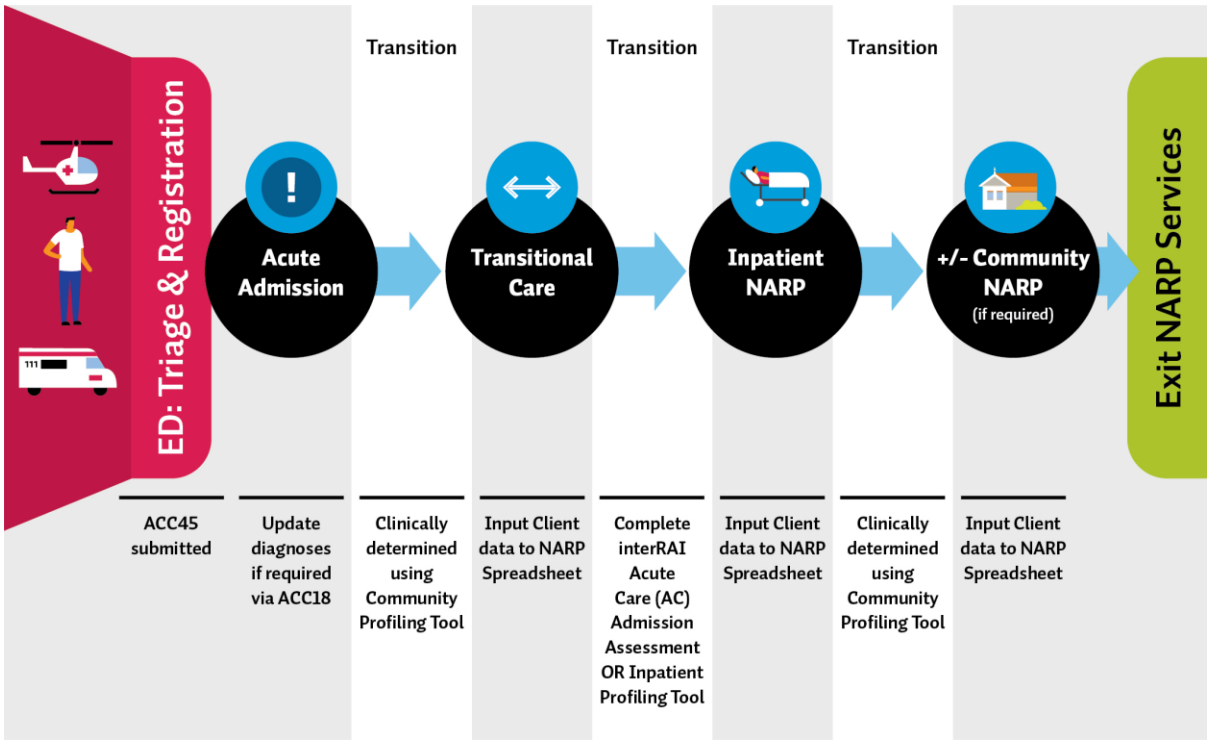

Figure 3: Transitional, Inpatient and Community Pathway

Scenario four: Agnes – Transitional and Community Pathway

Agnes is a 78-year-old who fractured her right neck of femur in a car accident. Agnes usually lives at home with her husband and walks independently without an aid.

Agnes presented to ED and was admitted to the orthopaedic ward where she had surgery.

Agnes was required to be non-weightbearing for six weeks. Her clinical team decided that Agnes would benefit from a period of transitional care where she could actively engage in rehabilitation.

Six weeks' later, Agnes was cleared to weight bear as tolerated. Agnes was profiled again using the community profiling tool to establish which community pathway would be used.

Agnes could begin her community rehabilitation while in transitional care which enabled a supported transition back home.

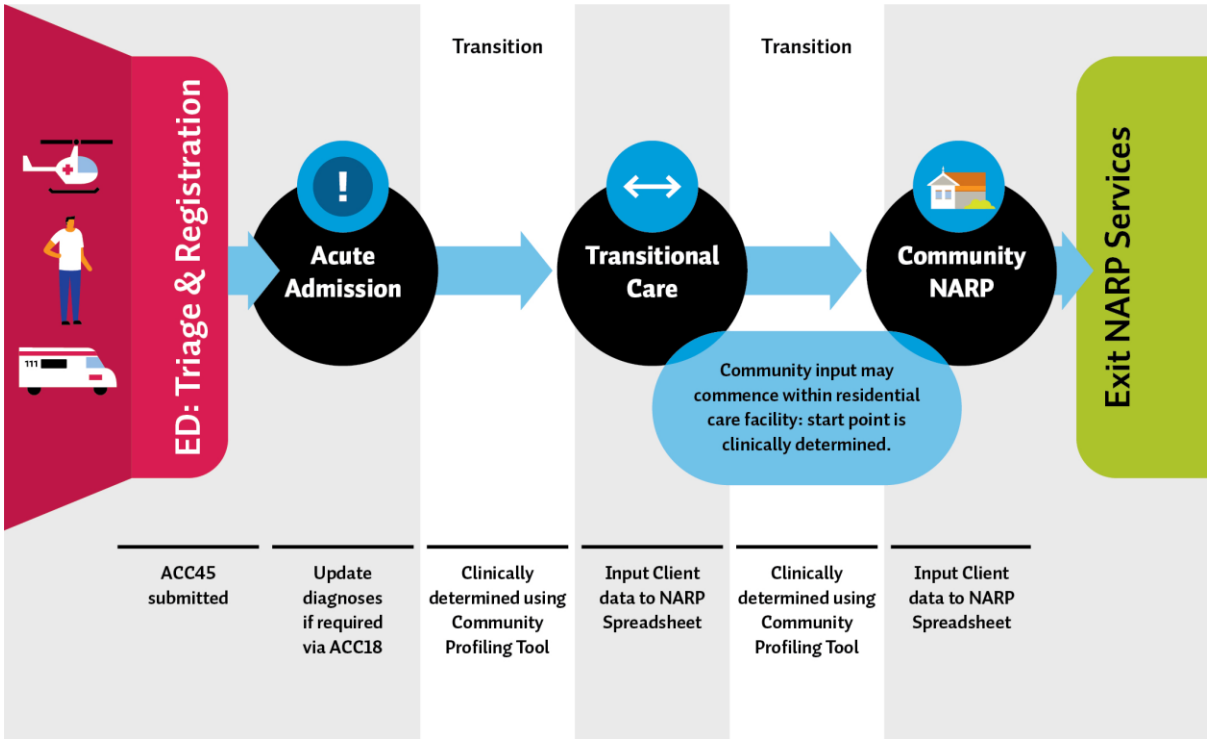

Figure 4: Transitional and Community Pathway