Welcome to the Wodonga campus of Albury Wodonga Health, it is also referred to as the Wodonga Hospital. It’s a great place to work so we hope you enjoy your placement with us!

The Allied Health department of Wodonga Hospital is located in Vermont St.

Allied Health Reception: (02) 60517400 Allied Health Fax Number: 60 517 430

Free parking is available at the football ground at the bottom of Vermont St.

Click here for maps of the AWH Albury and Wodonga campuses

On your first day report to the Allied Health front desk (just inside the door of the building below). Please introduce yourself and let the receptionist know who you are meeting so they can be informed. The front door is swipe card access only until 8.30am so if you come a little early you will need to wait for someone to swipe you in.

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**Wodonga Allied Health Teams**

Wodonga Allied Health works in multi-disciplinary programs or teams.

Although you will be here on placement related to your discipline, you will be working within a team (e.g. Physiotherapist in the Community Rehabilitation Team). There is more information about the teams in Wodonga on page 9 if you are interested.

Please read the information below and then return to the generic package in survey monkey to complete the orientation package.

**Acute placement**

You will be completing your placement on the acute unit. The OTs on the acute unit work as part of a multidisciplinary team including physiotherapy, social work, dietetics, speech pathology and an allied health assistant. They also work closely with medical and nursing staff.

The caseload is adult patients of varying ages and with a wide variety of medical conditions, often with complex socioeconomic backgrounds.

Referrals to OT are usually made for one of the following reasons:

- Decline in ability to perform ADL’s / difficulty coping at home
- Decline in ability to mobilise or transfer / change of mobility aid impacting on ability to safely manage in home environment
- Upper limb condition leading to functional impairment
- Risk of falls
- Acute neurological event e.g. Stroke, TIA
- Recent changes in cognitive state impacting on function
- Risk of developing pressure areas

All referrals to OT must be prioritised - high priorities include new stroke patients, patients at high risk of developing pressure areas, and patients for discharge that day who require OT input to facilitate safe discharge home.

The role of an OT is to complete assessments to determine the impact of a patient’s condition on their occupational performance. Assessments commonly completed include initial assessments, functional assessments, cognitive assessments, neurological assessments and home assessments.

Relevant intervention, including equipment provision, ADL retraining, upper limb therapy, and education, is then completed to facilitate safe discharge home if appropriate. OTs working in an acute setting will often refer patients to other services for ongoing management, for example, in-patient rehabilitation, community rehabilitation, transition care program, or the rural allied health team.
AGEM (Acute Geriatric Evaluation Management) Placement
AGEM provides interdisciplinary rehabilitation to appropriate patients at the Wodonga Hospital. It is generally referred to as “Slow stream” rehabilitation. There is also a rehabilitation ward at Albury Campus. Our team includes a rehabilitation consultant, a rehabilitation registrar, dietetian, occupational therapists, physiotherapists, social workers, speech pathologists, nurses and allied health assistants.

We see people of all ages, mainly 65 and over, for assessment and goal based therapy. We assist with or run group programs, such as Breakfast Group and Upper Limb Group (depending on the patient population). Our aim is to assist people in achieving their maximum level of occupational function to ensure a safe discharge from hospital.

The Occupational Therapists in AGEM complete assessment, treatment and intervention to facilitate participation in daily occupations. This may include: personal care, meal preparation, upper limb therapy, cognitive therapy, basic home modifications, mobility aids such as wheelchairs or scooters, and strategies to manage on discharge in relation to their occupational needs.

If you are looking for areas to research prior to placement, some general reading about equipment and / or stroke may be a good start.

The following are some good websites
- Aidacare – www.aidacare.com.au
Community Rehabilitation Centre (CRC) placement

You will be completing your placement in the Community Rehabilitation Team (also known as CRC – Community Rehabilitation Centre). CRC provides interdisciplinary rehabilitation to clients living at home in the Wodonga area. Our team includes physiotherapists, speech pathology, dietetics, social work, exercise physiology, nursing and an allied health assistant.

Click here to see the CRC brochure

We see people of all ages, at CRC or in their own home, for assessment and goal based therapy. We assist with or run group programs, such as Cardiac Rehabilitation, Falls and Balance Group, and a Community Access Group. Our aim to assist people in achieving their maximum level of reintegration into their community and meaningful activities.

The Occupational Therapists in CRC complete assessment, treatment and intervention to facilitate participation in activities of daily living. This may include upper limb therapy, mobility aids such as wheelchairs or scooters, basic home modifications, cognitive therapy, and strategies to reduce the impact of pain or anxiety.

If you are looking for areas to research prior to placement, some general reading about equipment and / or stroke may be a good start.

The following are some good websites

- Statewide Equipment Program (SWEP) re funding options for Victorian clients
TCP (Transitional Care Program) placement

The Transition Care Program (TCP) provides care and restorative services for a short period (up to 12 weeks) for older people who are ready for discharge from hospital.

The aim is to assist older people who are at risk of unnecessary long hospital stays or premature admission to a residential facility to optimise their functional capacity in a non-hospital environment. The Transition Care Team can also assist clients in finalising long-term care arrangements.

TCP services can be provided either in the client’s own home or in a community bed-based service.

Click here to see the TCP brochure

The Occupational Therapist works within an interdisciplinary team which includes care coordinators, physiotherapist, speech therapist, dietitian, social worker and allied health assistants. We see clients who are generally over the age of 65 years who meet the above criteria. Occupational Therapy intervention can include, but is not limited to the following areas:

1. Initial OT assessment to determine client goals during the TCP episode.
2. Personal ADLs – assessment/retraining
3. Domestic ADLs – assessment/retraining
4. Community ADLs – assessment/retraining
5. Home assessment – home modifications and equipment
6. Alternative driving options – scooter training and education
7. Cognitive assessment and retraining
8. Personal alarm assessment
9. Education regarding future planning/considerations
10. Pressure care management

If you are looking for areas to research prior to placement, some general reading about frailty and cognitive decline including the different types of dementia would be a good start. Familiarising yourself with different types of cognitive assessment (functional and standardised) is also suggested.

The Department of Health website has some further information regarding the Transition Care Program and links to other relevant programs / information:
RAHT (Rural Allied Health Team) placement

You will be completing your placement in the Rural Allied Health Team (also known as HACC – Home and Community Care). The RAHT team travel out into the community visiting clients in their own home. The client group is ‘frail aged – 65 or over and/or people with a permanent disability’ who live within the City of Wodonga, Alpine (East), Indigo and Towong Shires. There is an orientation folder when you start that covers eligibility criteria in more detail.

Click here to see the RAHT brochure

The Occupational Therapists in RAHT complete assessment, treatment and intervention to facilitate safety and independence in activities of daily living. This includes basic and complex home modification recommendations, equipment prescription (from shower stools and over toilet frames to complex pressure care and wheelchairs) and liaison with service providers/community resources.

If you are looking for areas to look up prior to placement home modifications and aids/equipment would be a good start.

The following are some good websites:

- Independent Living Centre websites
- Statewide Equipment Program (SWEP) re funding options for Victorian clients
Generic information:

**Supervisors**

For each placement you will be allocated a primary supervisor, who will be co-located with you at your placement site. This is the person who coordinates your placement and is responsible for your mid placement and final evaluation. During your placement you are likely to work with a range of other health professionals both within and outside your discipline, with a range of professional experiences.

It is important to remember that your supervisor(s) continue to carry a full workload during your placement, and you will need to be sensitive to his/her other responsibilities. This will also mean that you may be required to work more autonomously and independently during you placement.

Throughout your placement you will receive a mix of direct and indirect supervision. A range of facts such as the complexity of the activity/roles you are undertaking and your level of skills and knowledge determine the degree of supervision. Discuss with your supervisor early the types of supervision that will be provided, considering both the capacity of your supervisor and your own supervision requirements.

**Weekly student sessions (IPL)**

Each week a student interprofessional learning (IPL) session is offered at each campus. These are offered to allied health and nursing students and it is strongly suggested you attend. The sessions range from simulation to case studies to topics of interest designed to help you get to know the other students and their disciplines. The sessions are great fun and hope you can come along!

Please let Anna Sullivan (Allied Health Student Coordinator) know if you are not able to attend.

Wodonga IPL – Thursday 1-2pm in Vermont Court Room 7.

**Computer access:**

Generic access to the intranet will be provided for access to your discipline drive, student drive and other useful applications. Internet access is restricted to certain members of staff.

If you require the internet for patient care purposes ask your supervisor to log you on. For personal use out of hours or at lunch time, computer with unrestricted internet can be found in the CRC tea room and the main hospital cafeteria.

**Swipe Card:**

Your will be provided with a temporary swipe card to access parts of the hospital for Staff only. This should be worn at all times. Please return to front desk on your last day.

**Lockers:**

There are 4 student lockers available in the staff room, please ask during orientation. As you may need to share a locker please leave the key in the key box at reception.
**Photocopying:**

The photocopier is located outside reception in the alcove near the pigeon holes. Your supervisor will provide you with a code (codes also on green card above photocopier).

**Meal breaks**

Most people don’t take a morning tea/afternoon tea break however Friday morning tea is the highlight of the week, 10.30am in the staff room – come along!

Lunch is usually 12.30-1pm. Join us for lunch – either in the staff room, CRC courtyard or the grass area near dialysis.

**Questions/queries:**

If you have any concerns or questions during your placement please do not hesitate to ask one of us (if we don’t know, we can’t help!).

**Paging:**

Some acute staff wear a pager with the following numbers:

- Acute Dietician 406
- Acute OT 412
- Acute Speech 431
- Acute B/AGEM Physio 420
- Acute A/HDU/ED Physio 402
- Social Work 426
- Obstetric Social work 242

To page dial 88, enter the pager number (eg 406 for Dietican), wait for the voice prompt “Enter Message”, enter the extension you are calling from (usually located on the last button on the right hand side) followed by ##, wait for confirmation message “message sent”, then hang up.

**Completing the orientation package**

Reading this annexe was Step 2 in a 3 step orientation package.

Please now return to the generic orientation package in Survey Monkey which you should still have open on your computer.

This is the final step of the orientation package.
Allied Health Teams at Wodonga Campus

Acute Team

- Acute Unit (Wards A and B) have 28 beds encompassing general medical and some surgical patients. Surgical patients are mostly urology, gynaecology, ENT and some basic general surgery.
- 6 HDU beds
- The Obstetric Unit is one of the largest units in rural Victoria catering for an estimated 1600 births each year.

Community Health Team

- Multidisciplinary team providing outpatient services to enable Victorian residents suffering from a range of conditions to achieve and maintain optimal functional independence.
- Involved in the delivery of a variety of health promotion activities including Diabetes Education, Aquatic Physiotherapy, New Parents Group and Chronic Disease Self-Management

Community Rehabilitation Team (CRC team)

- Multidisciplinary team which aims to enable clients who are disabled, frail, chronically ill or recovering from traumatic injury to achieve and retain optimal functional independence. Clients with more complex needs and who require more than one discipline are seen by this team.
- General rehabilitation, cardiac rehabilitation and pulmonary rehabilitation
- Upper limb/hand therapy clinic
- Falls and balance program
- Lymphoedema
- Phone: 7411

Acute Geriatric Evaluation Management (AGEM)

- AGEM is a multidisciplinary slow-stream rehab service specialising in the care of patients over the age of 65 years who require further multidisciplinary therapy once medically well, to facilitate discharge to an appropriate destination. This program has 10 beds is located on Acute B ward in Wodonga.
- This is a goal based program with the aim to achieve optimal independence and quality of life.
- Phone: 7429

Pain Management Program

- Provides timely and efficient intervention to individuals, which meets best practice and uses a multi-disciplinary and consumer focused approach.
- Three week residential cognitive behavioral modification and physical reactivation program based on the biopsychosocial model of chronic pain and conducted by an interdisciplinary team.
- Phone: 7417
Rural and Allied Health Team (RAHT)

- The Rural Allied Health Team (RAHT) provides a range of home and clinic based professional services. We assist people to stay at home independently, including the frail, aged and younger people with disabilities, and their carers.
- They support and work with clients, carers and community service providers. The service will be designed to meet individual needs.
- Phone 7440

Transition Care Program (TCP)

- This program commenced in 2009 and is a slow-stream inter-disciplinary rehabilitation program based in clients home or extended care facilities.
- This program is for older clients (>65 years).
- It is for clients who have rehabilitation needs after an acute admission and live in the Albury district, as well as Wodonga, Indigo, and Towong shires.
- TCP currently has 16 beds – 8 community and 8 facility based beds.
- Phone : 7672

Hospital Admission Risk Program (HARP)

- HARP aims to prevent unplanned hospital admissions by helping people manage their health.
- HARP care co-ordinators work with people who have chronic health conditions and complex medical and psychosocial issues.
- People who are eligible for program have had admission to hospital for their chronic health condition, or are at risk of readmission or who are frequently presenting to the emergency department.
- The focus is on self- management and care co-ordination.
- The area is Upper Hume (Chiltern, Beechworth, Yackandandah, Corryong, Mt Beauty, Tallangatta, and Wodonga) and Albury to Thurgoona.
- Service is provided at the client’s home, community or in centre.
- Phone: 7615

Post Acute Care (P.A.C)

- Short term program that provides care co-ordination for people post discharge from hospital.
- Services can include home cleaning, personal care, shopping, meal preparation, nursing support and gap fill allied health.
- The services are purchased by the PAC program and can run for up to 4 weeks at no charge to the client.
- Phone: 7449

Inpatient Rehabilitation (temporarily at Albury Campus, moving to Wodonga mid 2015)

- Offers an integrated care program including allied health, medical and nursing care
- Aims to assist clients to achieve optimum independence and quality of life