Albury Wodonga Health Wodonga Campus
Occupational Therapy placements

**Acute placement**

You will be completing your placement on the acute unit. This comprises of the 16 acute beds, Close Observation unit of 6 beds plus 4 women’s surgical beds on the maternity ward.

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 and neurological 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. Our team includes a Geriatrician, a rehabilitation registrar, dietitian, occupational therapists, physiotherapists, social workers, speech pathologists, nurses and allied health assistants.

We see people over 65, for assessment and goal based therapy. We assist with or run group programs, such as Breakfast Group. 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 pressure care, cognitive decline/dementia and ageing are a good place to start.

Rehabilitation
The OT on the Rehabilitation Ward works within a multidisciplinary team including a rehabilitation consultant, a rehabilitation registrar, dietitian, physiotherapists, social workers, speech pathologists, nurses and allied health assistants.

We see people of all ages who have a variety of illnesses, conditions and disabilities. The OT in the rehabilitation team completes assessments, treatments and interventions to facilitate participation in the individual’s daily occupations. This may include: personal care, meal preparation, upper limb therapy, cognitive therapy, home modifications, prescribing equipment such as shower chairs, over toilet frames and wheelchairs, and working with clients to find strategies to manage their occupational roles. We also run group programs such as Breakfast Group and Skills Centre. Our aim is to assist people in achieving their maximum level of occupational function to ensure a safe discharge from hospital.
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 and surrounding areas. Our team includes physiotherapists, speech pathology, dietetics, social work, exercise physiology, nursing and allied health assistants.

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, Pulmonary Rehabilitation, Falls and Balance Group, and a Community Access Group. Our aim is 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

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

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: