



Conditions Eligible for Admission

Reference as of March 2018

The length of hospitalization at our hospital varies depending on each patient's condition, wishes, and discharge destination. It is determined in consultation with the physician and staff.

Condition	Admission Criteria	Maximum Length of Stay
Cerebrovascular disease, spinal cord injury, traumatic brain injury, post-shunt surgery for subarachnoid hemorrhage, brain tumor, encephalitis, acute encephalopathy, myelitis, polyneuritis, multiple sclerosis, brachial plexus injury, and similar conditions after onset or surgery, or conditions requiring prosthetic fitting and training	Within 2 months after onset or surgery	Up to 150 days
Severe cerebrovascular disease with higher brain dysfunction, severe head injury, and multiple trauma including head injury, after onset or surgery	Within 2 months after onset or surgery	Up to 180 days
Fractures of the femur, pelvis, spine, hip joint, or knee joint, or multiple fractures involving two or more limbs, after injury or surgery	Within 2 months after onset or surgery	Up to 90 days
Disuse syndrome caused by bed rest during treatment after surgery or for pneumonia, etc., after surgery or onset	Within 2 months after onset or surgery	Up to 90 days
Condition after injury to nerves, muscles, or ligaments of the femur, pelvis, spine, hip joint, or knee joint	Within 1 month after onset or surgery	Up to 60 days
Condition after hip or knee joint replacement surgery	Within 1 month after surgery	Up to 90 days

Content may be changed due to revisions in medical insurance reimbursement. Please confirm with the medical institution.



Admission Process

Admission Application

Please apply by phone through the consultation desk. Applications must be made by the medical institution currently providing treatment.

Consultation Desk:
Regional Medical Liaison Office

Reception Hours:
Weekdays 9:00-16:00

Admission Interview, Procedures & Tour

During the admission interview and ward tour, we will explain the admission guide and procedures.

We will provide the documents required for hospitalization. Please bring them on the day of admission.

From Hospitalization to Transfer to the Ward

In the general ward, admission examinations are performed. Rehabilitation begins as directed.

The patient is later transferred to the convalescent rehabilitation ward.



A Heartful Group that Values Human Connections

HEARTFULL GROUP

Social Medical Corporation Kyowakai

Guide to the Convalescent Rehabilitation Ward



Kano General Hospital 96 beds (8 private rooms)



By Public Transportation

1 minute north on foot from Exit 6 of Tenjinbashi-6-chome Station (Subway / Hankyu).

By Car

Please use our multistory parking garage. Nearby private parking is also available.

■ Operating hours: Monday to Saturday (excluding Sundays and public holidays), 9:00-16:00. Saturday until 13:00.

Parking Capacity
32

7-5-15 Tenjinbashi, Kita-ku, Osaka 531-0041

Inquiries (Direct) 06-6351-9810 (direct)



Kita-Osaka Hospital 38 beds (7 private rooms)



By Public Transportation

10 minutes west on foot from the north exit of Shin-Osaka Station (Osaka Metro Midosuji Line / JR Tokaido Line), or 10 minutes southeast on foot from the east exit of Mikuni Station (Hankyu Takarazuka Line).

By Car

Please use our multistory parking garage. Nearby private parking is also available.

■ Operating hours: Monday to Saturday (excluding Sundays and public holidays), 7:30-21:00. Saturday until 13:00.

Parking Capacity
18

2-7-17 Nishimiyahara, Yodogawa-ku, Osaka 532-0004

Inquiries (Main) 06-6395-1601 (main)



About the Convalescent Rehabilitation Ward

This ward provides early, intensive rehabilitation for patients who require rehabilitation due to cerebrovascular disease, fractures, and similar conditions.

Main Roles

1. Prevention

Prevent disability from the early stage

2. Functional Recovery

Help maximize recovery of impaired functions

3. Functional Compensation

Accurately assess residual disability and enrich daily life through compensatory strategies

Overview

Ward Staff

A multidisciplinary team supports you together!

At our hospital, we do not simply promote "functional recovery." We also help patients acquire activities of daily living such as eating, toileting, bathing, dressing, walking, and communication. This support is provided by a united team that includes physicians, nurses, physical therapists, occupational therapists, speech-language-hearing therapists, nursing assistants, pharmacists, dietitians, and social workers.



Physician

Assesses the patient's condition, provides treatment and medical management, and serves as the leader of the care team.



Nurse

Manages meals and oral intake while supporting rehabilitation for the daily activities needed after discharge.



Patient



Occupational Therapist

Provides training in practical activities needed for daily life according to the patient's condition, such as eating, dressing, and housework.



Speech-Language-Hearing Therapist

Provides rehabilitation for patients with speech, language, swallowing, or dysphagia-related disorders.



Dietitian

Provides nutritional management during hospitalization and nutritional guidance for after discharge.



Pharmacist

Provides medication counseling, medication management during hospitalization, and medication guidance after discharge.



Physical Therapist



Social Worker

Responds to daily-life problems caused by illness or disability and supports the use of medical and welfare systems.

Features of Our Hospital

- Our goal is to help patients regain many smiles. We strive to provide comprehensive rehabilitation programs tailored to each individual 365 days a year in a warm, home-like atmosphere.
- Our ultimate goal is to improve each patient's QOL (quality of life). We provide not only functional recovery training in the ward and rehabilitation room, but also outdoor walking practice to help patients develop the ability to adapt to life in the community.
- Before discharge, we help prepare the home environment by learning about the patient's home situation. We also provide rehabilitation guidance suited to daily-life situations, advice for family members on caregiving methods, and guidance on home modifications.

A Typical Day for Hospitalized Patients

6:00	Wake-up	Whenever possible, we encourage patients to eat at a table while sitting in a chair rather than in bed.	Individual Rehabilitation Function is regularly evaluated and discussed in conferences so that the most appropriate training can be provided according to each patient's condition.
8:00	Breakfast / Oral Care	Keeping the mouth clean through oral care helps prevent not only dental caries and bad breath, but also aspiration pneumonia.	
9:00	Rehabilitation / Bathing, etc.		
12:00	Lunch / Oral Care / Rehabilitation	Rehabilitation is provided according to the weekly rehabilitation schedule.	
18:00	Dinner / Oral Care / Leisure and Hobbies	During free time, patients spend time as they like, such as reading their favorite books or watching television.	
21:00	Lights Out		

Preparing for Life After Discharge

The convalescent rehabilitation ward is not intended for indefinite long-term hospitalization. Once admitted, let us gradually think about and prepare for life after discharge.

- Application for Long-Term Care Insurance**
We help establish long-term care insurance services to support home life after discharge. Use services suited to you and develop a clear image of life at home.
- Home Assessment**
To prepare for life at home after discharge, we conduct a "home assessment" to learn about the condition of your home. We provide advice on home-environment adjustments, goals to improve before discharge, and various assistive and welfare devices suited to daily life.
- Outing Training / Trial Home Stay**
With the attending physician's permission, patients may go out or stay overnight away from the hospital during hospitalization in order to prepare for discharge. The purpose is for both the patient and family to understand what the patient can and cannot do at home. It may also serve as a refreshing change of pace during hospitalization.
- Pre-discharge Care Conference (Discharge Joint Care Conference)**
The hospital staff share the patient's condition and medical information with home-care support staff, and together with the patient and family, discuss a discharge plan for living at home. We think together about how to help the patient live safely and in a way that is true to themselves.
- Home-Visit Rehabilitation**
Even after intensive rehabilitation in the convalescent rehabilitation ward, function may decline if rehabilitation suddenly stops after discharge. For patients certified as needing support or long-term care, our hospital has a system to continue rehabilitation after discharge in response to patient needs. (Please consult us regarding service areas.)

Note: The services provided and their order may differ by facility.