ACI NSW Agency for Clinical Innovation

Checklists

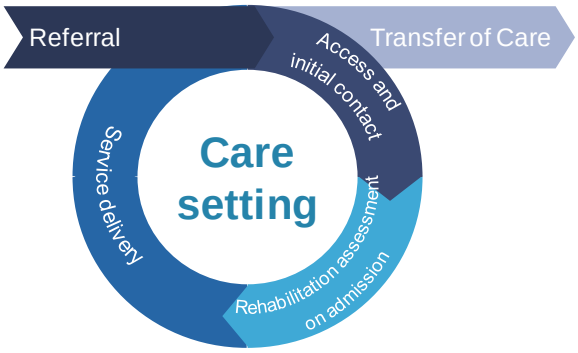
Checklists for each of the eight processes, tools, guidelines.

Checklists have been developed for each of the eight processes, tools and guidelines, these checklists are aligned to the core elements.

The checklists have been designed to help your LHD assess tools and resources from each of the rehabilitation care settings. It allows your LHD to rate the tools according to the inclusion of core elements of ‘good practice’ to identify gaps and opportunities for improvement.

Note: While the checklist has been developed to cut across all care settings, some core elements may not be applicable to all care settings.

Chapter 1: Across the patient journey



1. A process for appropriate care setting referral	• A tool to support consistent decision making regarding patients being appropriately referred into a rehabilitation setting • Ensuring patients receive the 'right care in the right place at the right time' across NSW Health
2. Standards for effective communication with patients and families/ carers	• Standards that ensure health professionals effectively communicate with patients and families/ carers • Effective communication and being informed is a right for each consumer in the health system and contributes to safe and high quality care.

Self assessment against the core elements/ criteria

To assess whether your rehabilitation service is in line with the core elements/ criteria for appropriate care setting referral, please complete the following checklist. This will help you determine the areas to enhance or develop your current policies, procedures, tools and resources for referring to the appropriate care setting.

Does your service have in place the following elements for referring to the appropriate care setting?

Communications checklist	Full compliance	Partial compliance	Not in place
Care will be delivered in the least resource intensive / safe setting, based on: • Admission criteria	☐	☐	☐
• Assessment by Rehabilitation Consultant or Rehabilitation Clinical Nurse Consultant to determine the most appropriate care setting	☐	☐	☐
• Acceptance of care by the Rehabilitation consultant	☐	☐	☐
• Appropriate care setting, appropriate care provider as close to home as possible.	☐	☐	☐
• Availability of care settings	☐	☐	☐
• Open and transparent patient and family/ carer communication throughout the decision making process in accepting referral and transfer to care	☐	☐	☐
• Patients and carers are involved in decision making about the care, and are provided with the options and limitations for accessing rehabilitation services to enable informed decision making about their care options.	☐	☐	☐
Transfers between care settings should be based on patient variables, delays due to provider factors (eg bed availability, awaiting home modifications) should be documented as delayed discharge.	☐	☐	☐

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Standards for effective communication with patients and families/carers

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Self assessment against the core elements/ criteria

To assess whether your rehabilitation service is in line with the core elements/ criteria for effective communication with patients and families/ carers, please complete the following checklist. This will help you determine the areas to enhance or develop your current policies, procedures, tools and resources for communicating with patients and families/ carers across the patient journey.

Does your service have in place the following elements for communicating with patients, families and carers?

Communications checklist	Full compliance	Partial compliance	Not in place
Admission			
Process to inform patients of their rights (eg handout given to patients)	☐	☐	☐
Process to identify the patient's preferred language for discussing health care (and ensure an interpreter is available as required)	☐	☐	☐
Process to communicate information about unique patient needs to the care team	☐	☐	☐
On assessment and treatment			
Identify and address patient communication needs during assessment	☐	☐	☐
A method to involve patients and families in the care process	☐	☐	☐
A process to accommodate patient cultural, religious or spiritual beliefs and practice	☐	☐	☐
Engagement throughout			
Patients and families/ carers are given clear verbal and written information about: • their diagnosis/ rehabilitation journey • expectations of their role in rehabilitation • discharge instructions that meets the patient needs	☐	☐	☐
Confirmation that the patient and their families/ carer understand the information.	☐	☐	☐
Appropriate information on all treatment options is provided to enable informed decision-making by patients /carers/and families and partnering with treatment providers in goal setting and the rehabilitation journey.	☐	☐	☐

Communications checklist	Full compliance	Partial compliance	Not in place
Carers are given the opportunity to ask questions, give feedback and discuss concerns and are linked into local services and support groups.	☐	☐	☐
Patients, their families/ carers are engaged during admission, assessment, treatment and discharge/transfer of care planning.	☐	☐	☐

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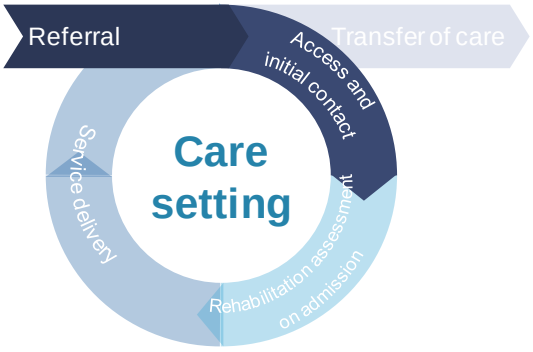
Chapter 2: Referral and admission



3. Eligibility, admission criteria, and guidelines for 'ready for rehabilitation'	**• Eligibility/ admission criteria are a documented agreed set of standards to promote appropriate admissions into care settings, promote optimal use of allocated beds and support services to manage patient flow between services and/ or settings.**
4. . Referral forms for Rehabilitation services across care settings	**• A referral from provides a standardised mechanism for referral into rehabilitation care settings. It provides background information for review of patients.**

Eligibility, admission criteria, and guidelines for 'ready for rehabilitation'

3

Self assessment against the core elements/ criteria

To ensure that your rehabilitation service is in line with the core elements/ criteria for effective eligibility / admission / ready for rehabilitation criteria, please complete the following checklist.

Do your documented eligibility/admission and 'ready for rehabilitation' criteria contain the following elements?

Admission criteria checklist	Full compliance	Partial compliance	Not in place
Patient is medically able to participate in the rehabilitation program in that care setting	☐	☐	☐
The patient has been assessed by an appropriate professional (eg rehabilitation physician, rehabilitation coordinator or other) as requiring rehabilitation in that care setting/environment (based on their physical/ medical/ functional, cognitive, psychosocial, social needs)	☐	☐	☐
There are clear, achievable rehabilitation goals that have been documented and agreed.	☐	☐	☐
Discharge destination has been discussed and agreed or the team is working towards a discharge destination	☐	☐	☐
The patient and/or carer consents and is able to participate in the rehabilitation process, including the intensity of therapy provided, in that care setting (i.e. motivation/ active patient participation)	☐	☐	☐
Patient and/or carer rehabilitation needs aligned to service delivery available in care setting	☐	☐	☐
Special needs are able to be met in that care setting (eg non-weight bearing patients)	☐	☐	☐
There is clear and accurate documentation of an ongoing management plan and necessary follow-up.	☐	☐	☐
The patient falls within the care setting case mix classifications agreed/ able to be accommodated in that care setting	☐	☐	☐
There is consideration of a trial of rehabilitation to determine a patient's ability to participate and potential to benefit from the program.	☐	☐	☐

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Referral forms for Rehabilitation services across care settings

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Self assessment against the core elements/ criteria

To assess whether your rehabilitation service is in line with the core elements/ criteria for your referral forms, please complete the following checklist.

Does your service have in place the following elements on your referral form?

Referral form checklist	Full compliance	Partial compliance	Not in place
Patient contact details	☐	☐	☐
Referring facility/ professional (team contacts)	☐	☐	☐
Principal diagnosis (clinical history/diagnosis)	☐	☐	☐
Reason for referral (identified issues, aim, goals, program type, program length, type of rehab/treatment)	☐	☐	☐
Present functional level	☐	☐	☐
Pre-morbid functional level and social history (eg lived alone in own home; residential aged care)	☐	☐	☐
Risk assessment (eg falls risk, behaviour, mental health)	☐	☐	☐
Familial/Carer and social support are available to participate and assist	☐	☐	☐
Discharge: • Discharge destination (planned) (eg home, Residential Aged Care Facility (RACF), child's home) • Potential barriers to discharge (eg requires home modifications)	☐	☐	☐
Previous rehabilitation admissions (location) /length	☐	☐	☐
Other relevant information (care setting specific) • Precautions / contraindications	☐	☐	☐

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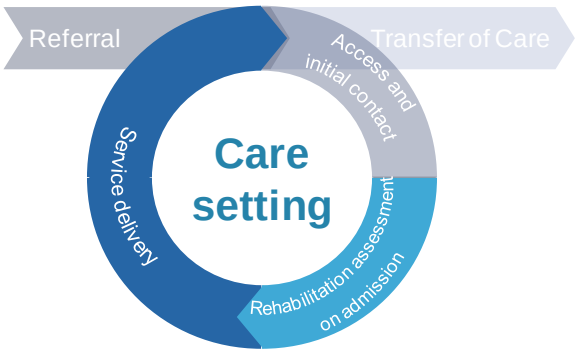
Chapter 3: Assessment and service delivery



5. Comprehensive assessment tool for utilisation by an MDT	**• A comprehensive assessment tool enables the MDT to assess patients using a validated, consistent and standardised process. • The tool allows a baseline measure on which to assess a patient'/s progress and monitor the effectiveness of treatment.**
6. Education programs for patient receiving rehabilitation	**• Education programs aim to actively engage patients and their families/ carers in their rehabilitation. It can assist them in understanding and managing their impairment, progression or disease or recovery, planned therapy and the rehabilitation program.**

Comprehensive assessment form and tool, for utilisation by a multi-disciplinary team

5

Self assessment against the core elements/ criteria

To assess your rehabilitation service is in line with the core elements/criteria for assessment forms and tools, please complete the following checklist.

Does your service have the following elements on you documented multi disciplinary assessment form and assessment tool?

Comprehensive assessment checklist	Full compliance	Partial compliance	Not in place
A comprehensive assessment is documented by the core multidisciplinary team on admission into the care setting	☐	☐	☐
Our assessment form includes: • Diagnosis • Medical history • Physical, psychological and social needs • Outcome measures • Transfer of care planning • Outline goals and timeframes to achieve the goals	☐	☐	☐
A standardised, evidence-based multi disciplinary assessment tool is used on admission and discharge at a minimum to assess outcomes of the program This is recorded on the assessment form or other relevant location	☐	☐	☐
Individual discipline specific assessment tools are used as appropriate throughout the admission to monitor individual disciplines treatment effectiveness	☐	☐	☐
The patient assessment will be repeated throughout the patient stay (at a minimum on admission and discharge for comprehensive assessments) to monitor treatment effectiveness. Frequency of assessment will be based on the assessment type and individual patient needs.	☐	☐	☐

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Self assessment against the core elements/criteria

To ensure that your rehabilitation service is in line with the core elements/ criteria for your education programs for patient and their families/carers, please complete the following checklist.

Does your rehabilitation education program for patients and their families/carers contain the following elements?

Patient / carer education checklist	Full compliance	Partial compliance	Not in place
Rehabilitation service has education programs in place for patients receiving rehabilitation	☐	☐	☐
The education program targets the individual patient and/or family/carer with the opportunity for patient and family/ carer to be included, provide input and feedback into the programs	☐	☐	☐
Where possible, education programs are provided in a group format	☐	☐	☐
Education tools provided to patients and their families/carers are disease specific and/ or discipline specific	☐	☐	☐
The education program is holistic covering both the physical, social and psychosocial aspects of recovery.	☐	☐	☐
The education program includes information brochures for patients and their families/ carer	☐	☐	☐
The education programs are goal focussed, individualised and flexible for use at various points in the patient's rehabilitation journey.	☐	☐	☐
The individualised education program materials are updated as the patient progresses in the rehabilitation program.	☐	☐	☐
The unit has checklists and/or a timetable to facilitate the patient receiving education.	☐	☐	☐
Education materials are available in a language that accommodates literacy, impairment and reading age, in addition to language spoken.	☐	☐	☐

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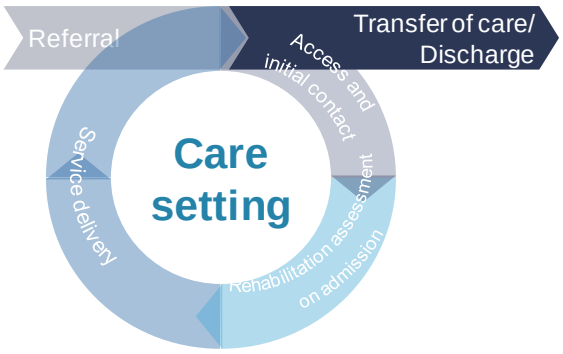
Chapter 4: Transfer of care / Discharge



7. Discharge principles	**• A set of documented elements that promote a consistent planning process from the point of admission for discharge/ transfer of care.**
8. Process for the transfer of information between care settings/ Clinical checklists to prepare for transfer of care	**• A documented process for the transfer of care, including information between care settings, aims to improve care coordination, patient care and patient flow through care settings.**

Transfer of Care / Discharge principles

7

Self assessment against the principles

To assess whether your rehabilitation service is in line with the core principles for discharge, please complete the following checklist.

Does your rehabilitation service incorporate the core principles for discharge?

Transfer of care / discharge principles checklist	Full compliance	Partial compliance	Not in place
Discharge planning commences at the point of admission	☐	☐	☐
Discharge planning is a transparent process that is collaborative and includes the patient/carer in the planning process	☐	☐	☐
Clear documented rehabilitation goals on admission	☐	☐	☐
A documented Estimated Date of Discharge (EDD) or treatment timeframe is set for each patient (in line with rehabilitation goals) to establish projected date to coordinate patients requirements and transfer of care	☐	☐	☐
The assessment of readiness for discharge is based on attainment of rehabilitation goals.	☐	☐	☐
Reassessment against patient goals takes place throughout the patient admission to ensure patient is tracking towards projected admission timeframes	☐	☐	☐
The rehabilitation goals have been met for that setting or the patient is unable to progress further with treatment	☐	☐	☐
The patient does not require ongoing care in that setting, but is safe to complete rehabilitation in a less resource intensive care setting or has completed rehabilitation for that episode of care.	☐	☐	☐
The discharge environment is suitable for the client needs (eg subacute setting, home, supported accommodation).	☐	☐	☐
The patient / carer as well as all medical, nursing and allied health staff involved in the patients care participate in decision making to transfer care / discharge.	☐	☐	☐

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A process for the transfer of care, including information transfer between care settings and/or to final discharge destination

8

Self assessment against the core elements/ criteria

To assess whether your rehabilitation service processes are in line with the core elements/ criteria for the process for the transfer of care, please complete the following checklist.

Does your service have in place the following elements for the transfer of care?

Transfer of Care process checklist	Full compliance	Partial compliance	Not in place
Clinician to clinician communication to agree on the transfer and confirm that the patient is 'medically stable' or other important admission criteria are met.	☐	☐	☐
A Transfer of Care summary with a clear management plan is sent to appropriate stakeholders or given to the patient	☐	☐	☐
A clinical checklist or equivalent is completed to prepare for transfer of care for all appropriate admitted patients before they return to the community. The transfer of care checklist must cover the following information: • Estimated date of transfer • Destination of transfer (including equipment/ home medications provided/ completed) • Notification transport booked • Personal items returned • Referral services booked • Patient/care education completed • Care plan • Transfer of care summary provided to patient that includes medication information, community and GP referral information and follow up appointments.	☐	☐	☐
All other documentation (eg diagnostic results) and referrals are packaged and provided for the patient at time of transfer of care	☐	☐	☐
Transfer of care to an inpatient setting should occur within agreed timeframes	☐	☐	☐

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