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# WA Health Day Therapy Unit Service Delivery Guidelines 2013

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## Executive Summary

The publication of the *WA Health Day Therapy Unit Service Delivery Guidelines – 2013* represents the culmination of work that first began in 2009 following a request to the Clinical Advisory Committee (Aged Care) by the Director-General of Health.

The request noted that a review of Day Therapy Units should take place with a view to expanding coverage, strengthening linkages to the primary care sector and developing strategies to improving the range of ambulatory subacute care services.

Two important pieces of work followed from this request. The first, The *Review of Day Therapy Units (DTUs) – June 2009,* concentrated on recommendations to strengthen and expand the range of subacute rehabilitation services provided by DTUs.

Specific recommendations were made to strengthen linkages across the continuum of care, promote service model development and provide system support.

The second piece of work, *Day Therapy Unit Model of Service Delivery - June 2010* concentrated on initiating dialogue and establishing the WA Day Therapy Unit network to promote the work of standardising service delivery models, documentation, key performance indicators, outcome measures and reporting practices across all DTUs.

Above all, it promoted the development of a comprehensive, integrated assessment for frail older people and a multidisciplinary approach to rehabilitation and management.

The document also advocated strongly for access to speciality clinics such as memory, falls and continence clinics across all DTUs in WA health.

The *WA Health Day Therapy Unit Service Delivery Guidelines – 2013* builds on the previous recommendations and takes the next important step to provide the practical material and guidelines for clinicians working in DTUs.

The guidelines are the result of an extremely positive and collaborative partnership between the WA Day Therapy Unit Network, the Aged and Continuing Care Directorate and the Aged Care Clinical Advisory Committee.

The next challenge is the successful implementation of the guidelines in Day Therapy Units across WA health.

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## Acknowledgement

These guidelines were developed in consultation with Day Therapy Unit (DTU) services, the Aged Care Clinical Advisory Committee (CAC), other health service providers and related Aged and Continuing Care Directorate (ACCD) program areas.

ACCD gratefully acknowledges the considerable time and effort of those involved in planning and developing these guidelines.

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# Introduction

The *WA Health Day Therapy Unit Service Delivery Guidelines* (guidelines) have been developed to support the consistent delivery of services at Day Therapy Units (DTUs) across Western Australia.

The guidelines aim to support the following key objectives for DTUs:

- streamline services
- increase efficiency in service delivery
- maximise consistency
- improve equity
- enhance coordination
- deliver evidence-based best practice

## Subacute Care

Subacute care services aim to improve the quality of life for patients who have a functional impairment by maximising their functional capacity and independence. Services focus on helping patients to maximise their functional capacities and independence through goal-oriented, time-limited intervention and multidisciplinary management.

Subacute care services include rehabilitation, geriatric evaluation and management, psycho-geriatric and palliative-care care types.

## A better patient journey

DTUs deliver non-admitted subacute care services that support patients, their family and carers during their transition from hospital admission to the community. These services can also prevent the need for a hospital presentation or stay, with many patients accessing these services directly from the community.

Demand for DTU services is expected to increase due to increased pressure on inpatient resources, demographic changes and the benefits of evidence-based care provided in the community.

A patient may require one or a combination of services delivered by a DTU, to meet their care needs so that each patient can receive the right care at the right time.

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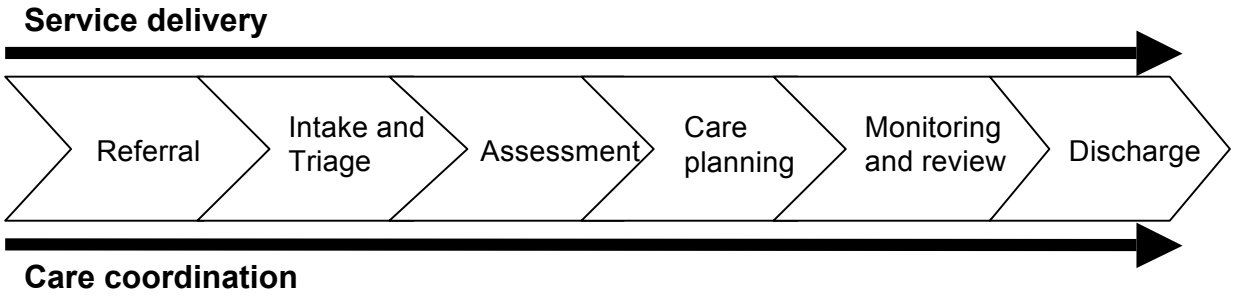
## Core components of care at a Day Therapy Unit

The core components of care outlined in the service delivery section of the guidelines are illustrated in Figure 1.

**Figure 1**




Aligning service delivery processes between DTUs within a Health Service will assist in more equitable care for patients and minimising duplication for patients and staff.

It will also assist in the quality and efficiency benchmarking across DTUs and facilitate evidence-based services and interventions delivery.

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# Policy context

## Subacute Care

In Western Australia (WA), there has been a historical concentration of health care and resources on acute care service provision, particularly within the metropolitan area. Significant potential exists to strengthen the provision of subacute care services across WA.

The WA Subacute Care Plan 2009-13, informed by the 2004 Reid Review, the WA Health Models of Care and the WA Clinical Services Framework 2005-15, aimed to invest in an increased range of subacute care services in the ambulatory setting and enable closer service delivery to where patients live. It also aimed to assist hospitals to be more efficient and sustainable by providing an increased range of discharge options from the acute care sector.

The National Partnership Agreement (NPA) on Hospital and Health Workforce Reform – Schedule C and Improving Public Hospital Services – Schedule E presented significant opportunities to strengthen and diversify WA subacute care services.

As a key component of subacute care services, WA DTUs received NPA funding to increase service delivery, especially in areas of need as well as establishing new DTUs in country areas.

## Activity Based Funding/Management

Over the last three years, WA Health has embarked on a statewide reform agenda to support the implementation of Activity Based Funding/Management (ABF/M). The purpose of ABF/M is to deliver safe care of the highest quality in a timely manner, to patients who require such services and within an efficiency-based funding model.

ABF means that health services are funded on the basis of their clinical activity. The intention is to provide a transparent link between the funding allocated by WA Health and the services provided to the patients and the community.

The *WA Day Therapy Unit Service Delivery Guidelines* are therefore developed in line with the following relevant WA and National policies and planning frameworks:

***WA Subacute Care Plan 2009-13***
http://www.health.wa.gov.au/publications/documents/SUBACUTE_CARE_PLAN_2009-13.pdf

***WA Clinical Services Framework***
http://www.health.wa.gov.au/publications/documents/CLINICAL_SERVICES_FRAMEWORK_WEB.pdf

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***WA Health Operational Plan 2012-13***
http://intranet.health.wa.gov.au/documents/docfiles/WA_Health_2012_2013_Operational_Plan.pdf

***WA Annual Performance Management Framework 2013-14***
http://activity/file.axd?file=2013%2f7%2f20120703_Performance+Management+Framework+2013-14_v3+0_FINAL.pdf

***Independent Hospital Pricing Authority (IHPA) Tier 2 Non-admitted Services Definition Manual 2012-13***
http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/non-admitted-care

***IHPA Tier 2 Non-admitted Services Compendium 2012-13***
http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/non-admitted-care

**Aged-Friendly Principles and Practices**
http://www.health.gov.au/internet/main/publishing.nsf/Content/8926D977475CB14ACA25732B004C432E/$File/age-friendly-principles-and-practices.pdf

**WA Aged Care Network – Model of Care for the older person in Western Australia**
http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Older_Person_Model_of_Care.pdf

**WA Aged Care Network – Rehabilitation and Restorative Care Service Model of Care**
http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/RRC_Model_of_Care.pdf

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## Supporting principles

The following principles support the DTU services. These principles are considered essential in delivering an effective service, achieving high quality outcomes for patients and ensuring the right services are delivered at the right time and right place.

**Patient-centred care**
Patients, their family and carers receive services that place the patient at the centre of their care. A collaborative and respectful partnership exists between the service provider and patient.

**Quality, evidence-based and timely services**
Patients, their family and carers receive services that meet quality standards, and based on the best available evidence and delivered in a timely manner.

**Equity of access to services**
Patients, their family and carers receive services that meet the needs of the patient. Access to services is determined on clinical need.

**Coordination and integration**
Patients, their family and carers receive services that are coordinated and integrated across all settings ensuring a seamless transfer of care across acute, sub-acute and community settings.

**Interdisciplinary approach**
Patients, their family and carers receive services that are based on an interdisciplinary approach.

**Promoting health independence**
Patients, their family and carers receive services that promote health independence.

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# WA Day Therapy Units

## Background

As part of the range of services provided in a subacute care sector, DTUs provide services to predominantly older persons in the ambulatory setting. The services provided by DTUs include geriatric evaluation and management clinics, nursing and allied health assessment and therapy. DTUs can be accessed following a hospital stay or directly from the community.

## Vision

"To assist patients and their family/carers to maintain, maximise or prevent deterioration of their functional capacity and independence, as well as self-managing complex care needs, and enabling them to remain in the community for as long as possible"

## Principles

- Provide safe, high quality care in the most cost-effective way
- Patient care is **individualised**, **patient-centered**, **goal-orientated** and **time-limited**.
- Patient care should be delivered through an **interdisciplinary** approach, with access to multidisciplinary rehabilitation and care management
- Patient care should involve the adoption of a self-management approach and encourage the active participation by patients in their own health care whenever possible
- Patient care is based on best practice evidence and delivered in a timely manner
- To facilitate patient flow from the inpatient setting to the community, and help to prevent hospital admission or transition to residential care
- To provide health promotion services where appropriate, and develop links with community health services
- The patients' rights should be respected in the decision making
- The roles and responsibilities of family and carers should be respected
- Actively engage with a patient's general practitioner (GP), other health professionals and support services

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## Type of services

### Rehabilitation

Rehabilitation provides individualised and time-limited assessment and therapy sessions by medical, nursing and allied health professionals. It is aimed at improving functional capacity.

The care is delivered according to a tailored care plan that is based on functional goals negotiated with the patient and their carers.

### Geriatric Evaluation and Management (GEM) Clinics

GEM clinics provide specialist assessment, diagnosis, intervention, management, education, advice and support to mainly older patients with geriatric syndromes and complex medical care.

Clinics are time-limited and where clinically indicated referral onto appropriate nursing and allied health for ongoing management. Specialty clinics may include:

- Geriatric medical clinics: for older patients with complex health care issues
- Falls clinics: for patients with falls, mobility and balance problems
- Memory clinics: for patients with cognitive complaints or dementia
- Continence clinics: for patients with bladder and/or bowel function difficulties
- North Metropolitan Health Service Parkinson's Disease Centre of Excellence at Osborne Park Hospital
- South Metropolitan Health Service Parkinson's Disease Centre of Excellence at Moss St, Fremantle Hospital and Health Service
- Other clinics such as Parkinson's disease, Stroke, Osteoporosis.

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## Guideline overview

The *WA Day Therapy Unit Service Delivery Guidelines* outline the key components of care for delivering a patient-centred DTU service that promotes consistent and coordinated care that is efficient and effective.

The guidelines are separated into three sections:

- *1. Service delivery* includes recommendations associated with key stages in the patient's journey through DTU.
- *2. Key Principles of service delivery* includes recommendations associated with key principles that support the delivery of DTU services.
- *3. Service management* includes recommendations associated with activity data management, Key Performance Indicators (KPIs) and quality management.

Each component of the guidelines is structured in the following manner:

- Service guideline, which is a description of the required service component
- Context, which outlines the reason for the guideline
- Recommendations, which outlines recommendations to assist services in implementing the guidelines.

These guidelines should be used in conjunction with health services' quality standards of care as well as local operational manuals.

It is anticipated that the guidelines will be reviewed and revised over time to ensure they reflect future development of the service environment.

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# 1. Service delivery

The purpose of DTU services is to deliver non-admitted subacute care to eligible patients in the ambulatory setting. Common across the DTUs should be the core components of care that define key stages in the patient's journey through DTUs, from entry, through to assessment, care planning, evaluation and finally discharge.

This section outlines the core components of care at each of these key stages. The core components of care are supported by key principles, including interdisciplinary care and evidence based practice, and is underpinned by person-centred care.

It is important patients access DTUs in a timely and seamless way. The consistency and equity of DTU services will be improved by ensuring each patient has access to initial triaging, coordinated assessment and care planning, and planned discharge.

**Guidelines in this section:**

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## 1.1 Referral

### Service guideline

*Each DTU should have a clearly defined and accessible single point of referral and eligibility criteria for all services to streamline entry and support intake and triage for patients.*

### Context

A well defined single point of referral provides a point for coordination of referrals from emergency departments, hospitals, Aged Care Assessment Team (ACAT), Rehabilitation in the Home (RITH), general practitioners (GPs) and other community services. It will facilitate the process of triage to determine prioritisation and service required for each patient.

A single point of referral eliminates confusion and ensures a consistent management of referrals by screening all incoming referrals with the same process.

DTUs and other hospital and community-based non-admitted health services (such as ACAT and RITH) within the same catchment area should collaborate to develop and implement a defined single point of referral.

### Recommendations

- Coordinate all referrals through a defined single point of referral.
- Eligibility criteria and referral process including referral information requirements are clearly documented and disseminated to relevant referrers.
- Process and conduct triage at the point of referral to determine prioritisation and services required *(refer to guideline 1.2 Triage)*
- Strategies are developed for continuing education and promotion of DTU services and contact details for the single point of referral to relevant referrers.
- DTU services adopt the common DTU referral form included in the Resource section and eventually electronic referral system to facilitate the collection and sharing of referral information.

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## 1.2 Triage

### Service guideline

*Triage will commence at the time the referral is received to determine a patient's need for services with consideration given to priority, eligibility and the type of initial assessment and services to be provided by DTUs.*

### Context

Triage is the process where the referral information, including presenting issues and medical history is used to determine the patient's risk, eligibility and priority for services.

Triage will commence at the time the referral is received which will facilitate appropriate acceptance of referrals and identify the likely DTU services required for each patient.

### Recommendations

- Processes for triaging a patient's eligibility, prioritisation and service requirement are defined and implemented.
- Processes are implemented for gathering adequate information regarding the referral to facilitate triage and prioritisation.
- Notify patients of their referral and acceptance to DTU services and inform them of the approximate waiting time for the service, if applicable.
- Notify referrers if and the reason why a referral is not accepted and any onward referral to a more suitable service, if available.
- Referrals that will facilitate safe and timely discharge from hospital or prevent a hospital admission should be triaged as a priority.

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## 1.3 Assessment

### Service guideline

*Every DTU patient should receive an interdisciplinary assessment to identify the current needs of the patient and to identify any underlying health issues. (Refer to guideline 2.2 Interdisciplinary approach)*

*Each patient will have access to a multidisciplinary team depending on the outcome of the interdisciplinary assessment.*

### Context

A multidimensional, interdisciplinary assessment is recognised as the best means for identifying the multiple medical, physical and psychosocial problems that may be impacting on patient's health, particularly in older persons and those with multiple and complex care needs.

Any issue identified can then be referred to the relevant Multidisciplinary Team (MDT) members for more specific assessment and inform the development and implementation of an appropriate care plan.

Duplication of assessment by individual professional disciplines should be avoided, as it is inconvenient for the patient and an inefficient use of resources.

### Recommendations

- All DTU patients will have a DTU Interdisciplinary Screen Form completed by the first clinician assessing the patient.

  Patients referred from the following sources may not need the interdisciplinary assessment **if the respective assessment forms or medical notes are accessible**:
  - ACAT
  - Care Coordination Team (CCT)
  - RITH
  - Hospital Inpatient wards

  (Clinical judgment will need to be utilised to determine the appropriateness and completeness of the information and whether additional assessment is required.)

- DTU patients attending GEM specialty clinics (such as Falls and Memory clinics) will also have an DTU Nursing Observation Form completed.

- Avoid duplication of assessment, where possible by utilising key medical, functional and social Information from the Interdisciplinary screen form across clinical disciplines and other support services.

- Move towards electronic assessment forms that can be recorded and shared among clinical disciplines and other support services to avoid duplication and also improve efficiency.

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## 1.4 Care Planning

### Service guideline

*A care plan should be developed and implemented to meet the needs and goals of each patient following the initial assessment.*

### Context

Care planning is the process of outlining how issues identified in the interdisciplinary assessment will be managed. The purpose is to set out goals with the patient and establish how these goals will be met through services provided at the DTU.

Each patient will have different needs and expectations. A consultative, collaborative approach (ie patient centred) that actively involves the patient, their family/carers and an interdisciplinary team ensures the best possible outcomes for the patient.

Care plans may take different forms and will depend on the needs of each patient.

Care plans should be reviewed and modified in response to changes in the patient's circumstances, conditions or as additional issues present.

To ensure appropriate expectations of DTU services, a timely plan of transition and discharge is an important part of the care plan and should be developed as early as possible.

### Recommendations

- Processes for developing a care plan are defined and documented.
- The care plan is goal-oriented, time-limited and based on the best available evidence.
- The clinicians, patients, their family and carers should work in partnership to develop the care plan.
- The care plan may involve interventions by only one clinician or may require input from the multidisciplinary team.
- For complex cases, a coordinated approach should be utilised to develop a care plan that meet the goals and needs.
- DTU services adopt the common care plan form included in the Resource section.
- When appropriate, provide a copy of the care plan to the patient to ensure the patient is aware of the goals and treatment plan.

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## 1.5 Monitoring and review

### Service guideline

*In conjunction with the patient, DTU services should monitor and review their care plan during the intervention timeframe and when goals have been achieved.*

### Context

As the needs of a patient can change, it is important to regularly review (in conjunction with the patient) their needs and management plan. The need for, and timing of a review should be determined as part of the care plan.

For patients with complex health issues and/or those who require multidisciplinary input, regular reviews of a patient's care needs by the multidisciplinary team throughout out their intervention will ensure that appropriate and coordinated care is provided.

Proactive monitoring can help to identify the need for alternative or additional service provision, and facilitate timely discharge from DTU services.

Evaluations through and at the end of intervention ensure that all aspects of the care plan were delivered and assessed for effectiveness.

### Recommendations

- Processes for monitoring and reviewing care plans are defined and documented.
- The care plan and goals for each patient are reviewed on an ongoing basis.
- The review can be in different format depending on local processes and patient needs.
- For complex cases requiring multidisciplinary input, the care plan review should be coordinated and involve the multidisciplinary team.
- The care plan and achievement of the patient's goals are reviewed following the completion of the intervention to determine effectiveness.

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## 1.6 Discharge

### Service guideline

*Discharge from DTU services should be planned and coordinated in partnership with the patient and carer.*

### Context

DTU services are goal-oriented and time-limited therefore adequate and clear processes for safe and timely discharge are required.

DTU service patients are referred from hospital inpatient wards or the community, and often face a change in their health status or functional capacity. Well planned and coordinated discharge will ensure timely referral to ongoing service provision if required to assist the patient to live in the community and self-manage.

Timely patient discharge will assist with DTU effectiveness and better access for new patients. This is particularly important in the context of increasing demand on non-admitted services to facilitate patient flow through the hospital setting.

Appropriate communication and transfer of information to ongoing service providers and other relevant parties, including the patient's GP is essential in ensuring ongoing support and management for the patient.

### Recommendations

- Processes for discharge planning are defined and documented.
- Discharge planning should be coordinated and commence as early as possible on the patient's journey through the service and regularly reviewed and updated if required.
- When required, link patients with ongoing community services (such as Home and Community Care) or other ongoing programs (such as Community Physiotherapy Service) to improve or maintain their level of function.
- A discharge summary including a summary of the intervention provided, outcomes achieved, and referral to ongoing services should be provided to each patient's GP, and filed in the medical record.

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## 2. Key principles of service delivery

A number of key principles underpin service delivery to support a patient-centred care and a seamless patient journey.

Patient-centred care is based on a collaborative and respectful partnership between the clinicians and the patient. This includes involving patients, family and carers in goal setting and decision making. Involving patients help clinicians to better recognise and deal with issues that are central to the patient's recovery and promoting health independence.

Patient-centred care respects the wishes and needs of the patient and carers. DTUs have a responsibility to provide care that takes each patient's needs and preferences into account, including but not limited to preferences based on religious beliefs, language or cultural background.

**Guidelines in this section:**

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## 2.1 Interdisciplinary approach

### Service guideline

*Provide an interdisciplinary approach to patient care, with access to a multidisciplinary team when clinically indicated.*

*Where a patient only needs single discipline input, an interdisciplinary approach to care is still recommended.*

### Context

In an interdisciplinary approach, team members from different disciplines collectively set goals and share resources and responsibilities. The shift towards an interdisciplinary approach to care better reflects the person-centred model of care.

An interdisciplinary approach is characterised by:

- improved collaboration and quality of care as a result of individual discipline using their knowledge of other disciplines
- coordination through teamwork to ensure all aspects of the patient's care are addressed
- improving efficiency through eliminating duplication by providing integrated and coordinated care based on the patient's needs
- Optimal care planning with the patient's goals as the focus of the care plan

An interdisciplinary approach facilitates teamwork and coordination to ensure all aspects of the patient's care are addressed. This is particularly important for patients with complex health issues.

### Recommendations

- Provide an interdisciplinary approach to care with access to a multidisciplinary team when clinical indicated.

- Encourage team building where team members share knowledge from their discipline and where team members appreciate the unique skill set that each discipline contributes in the overall provision of care.

- Each patient should receive an interdisciplinary assessment and be referred for discipline specific and/or specialty medical assessment where appropriate (refer to guideline 1.3 Assessment).

- Foster an interdisciplinary approach by ensuring all members of the team are aware of the finds of, and have the opportunity to contribute to the assessment, care plan, and monitoring and review process.

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## 2.2 Evidence-based practice

### Service guideline

*DTU Services are planned and delivered based on the best available evidence and in the most effective way.*

### Context

Evidence-based care results in improved health outcomes for patients. DTUs should ensure, whenever possible, services are delivered in line with this evidence.

DTUs should routinely utilise validated outcome measures and key performance indicators (KPI) to evaluate service effectiveness.

### Recommendations

- Services and interventions are based on the best available evidence.
- Evidence-based clinical practice guidelines are used, when available.
- Interventions that are most effective are utilised, whenever possible.
- Evaluate DTU services and procedures regularly to ensure care is delivered effectively.

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## 2.3 Self-management

### Service guideline

*The principles of self management should underpin interactions between patients/carers and clinicians when clinically appropriate. Clinicians should explore the most effective method to encourage self-management for the individual patient.*

### Context

There is growing recognition that patient and family/carers have enormous potential to influence the health outcomes if they are actively involved in decision making and are provided with quality information and appropriate self-management skills.

Improving the capacity of patient and family/carers to manage the health issues may reduce the demand on health care services.

### Recommendations

- Encourage patients, their family and carers to actively self-managing their conditions, where appropriate.
- Educate patients and family/carers where appropriate.
- Encourage collaboration between patients/family/carers and clinicians to facilitate self-management and ensure all are actively involved in decision making.
- Provide information that is consistent across the multidisciplinary team.

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## 2.4 Engagement with general practitioners (GPs)

### Service Guideline

*Actively engaging with a patient's GP*

### Context

GPs are integral to patient management and ensuring coordinated care in the community. Engaging with GPs through communication and shared care planning will improve the continuity of care for patients.

### Recommendations

- Obtain the consent of patients to share information with their GPs (as part of the guideline 1.3 Assessment).

With the patient's consent:

- Request from their GP any relevant, up to date care plans, medical history and medication list when required.

- Provide verbal information via the phone to the GP for urgent issues when appropriate.

- Provide GP with a copy of clinician assessment and/or discharge summary of intervention and therapy provided (refer to guideline 1.6 Discharge).

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## 2.5 Working with Aboriginal and Torres Strait Islander (ATSI) patients

### Service guidelines

*DTU services should provide equal access to ATSI patients and ensure appropriate resources to facilitate high-quality care.*

### Context

Providing patient-centred care involves respecting patients' cultural and religious beliefs and delivering culturally appropriate services.

ATSI patients, their family and carers can have difficulty accessing health services and following care plans. This may be due to factors such as:

- Unfamiliarity of the complex mainstream health service system
- Differing cultural norms and beliefs regarding health care.

### Recommendations

- Consider the cultural context of patients throughout the patient journey.
- Provide staff with information of the cultural diversity of patients in the community to assist staff engage these groups and provide culturally appropriate care.
- Facilitate access to ATSI liaison officers and services as required.
- Provide staff with cultural awareness training.

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## 2.6 Working with patients from culturally and linguistically diverse (CALD) backgrounds

### Service guidelines

*DTU services should provide equal access to patients from CALD backgrounds and ensure appropriate resources to facilitate high-quality care.*

### Context

Providing patient-centred care involves respecting patients' cultural and religious beliefs and delivering culturally appropriate services.

People from CALD backgrounds can have difficulty accessing health services and following care plans. This may be due to factors such as:

- Unfamiliarity of the complex Australian health service system
- Differing cultural norms and beliefs regarding health care
- Communication difficulties and language differences.

### Recommendations

- Consider the cultural context of patients throughout the patient journey.
- Provide access to qualified interpreter services either in person or via telephone, where necessary.
- Provide patients with education and information material in multiple languages where possible.
- Provide staff with cultural awareness training.

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## 3. Service management

Ensuring the accurate collection and reporting of activity data and performance indicators is essential to provide high quality services.

**Guidelines in this section:**

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## 3.1 Patient record management

### Service Guideline

*Ensure relevant clinical information is accurately and clearly documented within the patient medical record.*

### Context

The patient medical record provides the DTU services with relevant patient information and the plan of care that is required for consistency and continuity of care.

The counting unit for non-admitted activity under ABF is “service event”. For any clinical activity to be counted as a service event there must be **a dated entry in the patient’s medical record** that documents the clinical interaction between the healthcare providers and the patient.

DTU services are responsible for timely documentation and maintenance of patient medical records, while respecting patient privacy in accordance with privacy laws.

DTU services should consider having a single patient medical record if possible to reduce duplication of documentation and facilitate better communication and care coordination.

### Recommendations

- Policies and procedures on how patient medical records are managed are clearly identified and documented.
- Staff are oriented to record management and documentation processes.
- Patient medical management is consistent with the Health Services’ policies and procedures.
- Patient medical records contain relevant and current information.

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## 3.2 Activity data management

### Service Guideline

*DTU services should collect and report patient-level non-admitted activity data through an approved Patient Administrative System (PAS) to meet local and national ABF reporting requirement.*

### Context

As WA Health transitions to an ABF funding environment, significant changes have been implemented to ensure WA Health is able to deliver safe care of the highest quality at an agreed price.

With the implementation of ABF/M, WA Health is required to report patient-level non-admitted outpatient activity electronically to the Independent Hospital Pricing Authority (IHPA).Suitable and approved electronic systems must be implemented at each service to report all patient-level non-admitted outpatient activity.

The current approved systems are the Department of Health (DoH) corporately managed systems of **TOPAS, webPAS and HCARe.**

Consistent business practices around activity management including data recording across DTUs will facilitate efficiency and improved transparency.
(Please refer to WA Non-admitted Rehabilitation/GEM activity data management framework)

A key element of ABF is about delivering safe high quality care in the most cost-efficient way. The monitoring and analysis of activity data will allow the DTU services to evaluate the cost-effectiveness of the service and facilitate efficiency improvement. Accurate data enables the DTU services to monitor performance and provides accountability for ongoing funding.

### Recommendations

- Record and report DTU clinical activity in one of the three approved Patient Administrative System (PAS) – **TOPAS, webPAS** and **HCARe**.
- Processes for data collection and reporting are clearly defined and documented.
- Regularly monitor and evaluate your service and facilitate efficiency improvement.

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## 3.3 Patient outcome and performance management

### Service guidelines

*DTU services should collect and analyse patient-level quality data to facilitate ongoing performance management.*

### Context

To ensure that DTU services are delivering safe, high quality care, it is important for each service to collect and analyse patient-level quality data to facilitate ongoing performance management.

The collection of common key performance indicators (KPIs) across WA DTU services will provide demographic, clinical and resource utilisation data essential for evaluating service effectiveness and improve transparency and accountability.

The common DTU KPIs align with the WA Performance Management Framework which is a key element of ABF/M and cover the key performance domains of effectiveness, efficiency, equity, and sustainability.

### Recommendations

- Collect common DTU key performance indicators as listed in the Resource section using an appropriate data management system.
- Clearly define and document data collection processes.
- Regularly monitor and evaluate your service to facilitate ongoing performance management.
- Continue to update the common DTU key performance indicators and modify as clinical practices and services delivery changes with best-evidence.
- Establish a WA wide DTU database to facilitate accurate data collection and benchmarking.

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## 3.4 Audit and research

### Service guidelines

*Participation in clinical or health service audit and research is encouraged.*

### Context

Audit has an important role in evaluation of the service and patient management, encourages the provision of quality care and developing best practice management.

Research activities include direct involvement in conducting research or participation in research undertaken by another service or organisation.

### Recommendations

- Encourage audit and research within the service, where appropriate.
- Encourage staff participation in research conducted externally, where appropriate.
- Research undertaken is administered in accordance with health service guidelines and standards.

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# Resources

This section contains all resources and references referred to in the guidelines.

## Activity Based Funding and Management

**WA Activity Based Funding and Management website***:* http://activity/

**Independent Hospital Pricing Authority (IHPA)website***:*
http://www.ihpa.gov.au/internet/ihpa/publishing.nsf

### Weighted Activity Unit (WAU)

WAU is a unit of activity weighted for relative cost which then enables a cost comparison of different types of activity to be made within an output class.

It is determined by IHPA annually.

### National Efficient Price (NEP)

The NEP is determined by IHPA annually and is based on the projected average cost (PAC) of a WAU after the deduction of specified Commonwealth funded programs.

Further information on the national activity classification and weightings can be located at http://www.ihpa.gov.au/internet/ihpa/publishing.nsf

### State Efficient Price (SEP)

Due to the different circumstances and characteristics of the WA public health system, it is recognised that there is a gap between the PAC and the cost of providing the activity in WA.

The state price is set on the national PAC with adjustment related to the state transitioning price.

Further information on state prices can be located at:
http://activity/file.axd?file=2013%2f9%2f12673-health-activity-purchasing-intentions-FINAL.pdf

### Tier 2 Non-admitted Care Services

The ABF classification system for non-admitted care is known as the “Tier 2 Non-admitted Care Service”

Further information can be located at:
http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/non-admitted-care

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## Patient outcome and performance management

| Domain | KPIs | Data source |
|---|---|---|
| **Demographics** | • Age<br>• Sex<br>• Indigenous status<br>  ○ Aboriginal but not Torres Strait Islander Origin<br>  ○ Torres Strait Islander but not Aboriginal Origin<br>  ○ Both<br>  ○ Neither<br>  ○ Not stated/inadequately defined<br>• Residential Post codes<br>• Residential status (%)<br>  ○ Lives alone (no support required)<br>  ○ Lives alone (with external support)<br>  ○ Lives with others (no support/care provided)<br>  ○ Lives with others (who provide support/care)<br>  ○ Lives with others (external support)<br>  ○ Not stated/inadequately defined | **TOPAS/ webPAS/ HCARe** |
| **Service accessibility** | • Referral source (%)<br>  ○ Hospital<br>  ○ RITH<br>  ○ Community<br>• Visit reason<br>• **Wait time** (Average and Median) = date being offered 1st appointment date – Date receipt of referral<br>• **Length of DTU service** (Average and Median) = Discharge date – 1st appointment date<br>• Number of patients referred per month<br>• Number of new patients per month<br>• Number of follow up patients per month<br>• Numbers of clinicians accessed (Average)<br>• Number of clinics accessed | **TOPAS/ webPAS/ HCARe** |
| **Service utilisation** | • Number of patients attended per month<br>• Number of patients discharged per month<br>• Number of patients in groups sessions<br>• Average number of service events per patient | **TOPAS/ webPAS/ HCARE** |

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| | | |
|---|---|---|
| **Patient Care** | • % of DTU patients seen who have had a multidisciplinary care plan developed and documented (as part of Sch C & E reporting requirement)<br>• % of DTU patients seen where a standardised clinical outcome instrument was used (as part of Sch C & E reporting requirement)<br>• *Australia Lawtons IADL Scale* – admission & discharge<br>• *MMSE and/or AMTS*<br>• Profession specific outcome measures:<br>  ○ Doctor: Documented medical plan and letter sent out to referrer and GP within **2** weeks of assessment<br>  ○ Physiotherapy: De Morton Mobility Index (DEMMI), Timed Up and Go Test (TUG) | **Appropriate Database** |

PLEASE PRINT CLEARLY

| XXX Health Service<br>**DAY THERAPY UNIT**<br>**MULTI-DISCIPLINARY**<br>**REFERRAL FORM** | Surname | UMRN | |
|---|---|---|---|
| | Given Names | DoH | Gender |
| | Address | | |

**To assist eligibility assessment -** Is/Does the patient:

- ☐ Reside within the **XXX Health Service** postcodes listed below;
- ☐ Require a **multidisciplinary assessment and therapy program** or **Geriatric assessment**;
- ☐ 65 years of age or over, OR if Torres Strait Islander or Aboriginal 45 years of age or over;
- ☐ Benefit from short-term rehabilitation or restoration;

**NOTE**: Younger adults with neurological disabilities and/or multiple health problems; AND patients who usually reside outside the **XXX** postcodes will be considered on an individual basis.

**XXX Post Codes:**

## CLIENT DETAILS

| Client contact numbers: | Visit address (if different from patient label): |
|---|---|
| Contact person:<br>(if not client) | |

| | | |
|---|---|---|
| **Next of Kin**: | Contact details: | Relationship: |
| **GP** | Phone: | Address: |
| **Language**: | **Interpreter** ☐ yes ☐ no | **Indigenous Status:** ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither |

## CLINICAL DETAILS

Discharge date or anticipated discharge date: / / Discharge from:

| **DIAGNOSIS/REASON FOR REFERRAL** | **PAST MEDICAL HISTORY** |
|---|---|
| (Include operation / procedure / date) | |
| | |
| | |
| | |
| | |

**Referrer**: Profession: Phone: Date: / /

**Referred for:**

| | | |
|---|---|---|
| ☐ Geriatric Assessment | ☐ Memory Evaluation Clinic | ☐ Falls Clinic |
| ☐ Occupational Therapy | ☐ Physiotherapy | ☐ Speech Therapy |
| ☐ Continence Clinic | ☐ Dietetics | ☐ Social Work |

## SOCIAL & DOMESTIC DETAILS (if known)

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced or separated ☐ Other _____

Living arrangement: ☐ Alone ☐ With spouse/partner ONLY ☐ With other relatives/persons ☐ Other _____

| Medicare Number: | Health Care Card Number: | Pension Number: |
|---|---|---|

DVA: ☐ Yes – circle type: *White* /*Gold* ☐ No DVA

Previous ACAT assessment: ☐ Yes - assessment date: ____ /_____ /_____ ☐ No ACAT

Approval type: ☐ High Care ☐ Low Care ☐ CACP ☐ EACH ☐ TCP ☐ Respite ☐ Residential

Service provider:_____

Service type/care provided:

Please fax completed referral forms to XXX

PLEASE PRINT CLEARLY

**XXX Health Service**
**DAY THERAY UNIT**
**REFERRAL FORM**

**PATIENT NAME:**

**UMRN:**

PATIENT LABEL

| **CLIENT-CENTRED GOALS FOR DTU INTERVENTION**<br>All disciplines please liaise and complete this section. Please tick DTU professions required |
|---|
| **Medical** (Please include copies of blood tests, reports/investigations, medications and any recent correspondence from specialists involved in care) |
| |
| |
| |
| **Allied Health** |
| |
| |
| |
| |

| **FUNCTION**<br>**Please complete section below. Liaise with client and carer** | | | |
|---|---|---|---|
| I = independent<br>A = assisted | PRE-ADMISSION | CURRENT | ASSISTED BY:<br>(agency / carer) |
| **AMBULATION** | ☐ I ☐ A | ☐ I ☐ A Details (assistance, aids, distance, stairs, WB status): | |
| **TRANSFERS** | ☐ I ☐ A | ☐ I ☐ A Details (supine-sit, STS, bed mobility, car transfers): | |
| **PERSONAL CARE** | ☐ I ☐ A | ☐ I ☐ A Details (washing, dressing, grooming, toileting, eating): | |
| **MEDICATIONS** | Assistance required ☐ yes ☐ no:<br>Dose administration aid? | | |
| **FALLS HISTORY** | (past 6mths): | | |
| **COMMUNICATION** | Difficulty ☐ yes ☐ no Detail:<br>(consider involving SP) | | |
| **COGNITION** | (memory impairments, insight etc): | | |
| **CONTINENCE** | (incontinence, constipation, nocturia, UTI, management, aids): | | |
| **VISION / HEARING & SENSATION** | (visual / hearing aids, sensory impairments): | | |

| **OFFICE USE ONLY** | **Multidisciplinary Team Meeting** | | | Comments |
|---|---|---|---|---|
| Accepted to DTU ☐ Yes ☐ No | | | | |
| ☐ Medical | ☐ Nursing | ☐ Speech Therapy | ☐ Clinical Psychologist | |
| ☐ Occupational Therapy | ☐ Podiatry | ☐ Dietetics | ☐ Continence Nurse | |
| ☐ Physiotherapy | ☐ Social Work | ☐ ACAT | ☐ Falls Specialist | |

| **Coordinator** | | **Administration** | |
|---|---|---|---|
| Contact Patient/Carer | ☐ **Yes** ☐ **No** | Appointment Card & Letter Posted | ☐ **Yes** ☐ **No** |
| Appointments Booked | ☐ **Yes** ☐ **No** | Acknowledgement of Referral Posted | ☐ **Yes** ☐ **No** |
| Date: / / | Time: | Medical Record Retrieved/Made up | ☐ **Yes** ☐ **No** |

| | | | |
|---|---|---|---|
| Hospital _____ | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| **DTU Interdisciplinary Screen** | | Telephone | |

| **Please complete on first session, unless referred from ACAT /DTU /RITH and have access to assessment form** | | |
|---|---|---|
| **Client informed consent for assessment and sharing of information:** ❑ **Yes** ❑ **No** | | |
| Assessment Date: | Assessor: | Referral source: |
| NOK/Main Contact: | Tel: | Relationship: |
| Usual GP: | GP Tel: | Fax: |

| **Reason for Referral:** | Initial | Date |
|---|---|---|
| | | |

| Current history /precautions: | Past medical history: |
|---|---|
| | |
| | |
| | |
| | |
| | |

| **Social & Domestic Assessment** | Initial | Date |
|---|---|---|

Employment status: ☐ Employed ☐ Unemployed ☐ Retired for age - Pension / Self-funded

☐ Retired for disability Please state previous employment:

Marital status: Driving Status:

Living arrangements: ☐ Spouse/partner ☐ Relative/friend ☐ Alone

Carer: ☐ Yes ☐ No Carers Name:_____ Relationship:_____

Age >70yr: ☐ Yes ☐ No Carer living-in: ☐ Yes ☐ No Uses respite: ☐ Yes ☐ No Employed: ☐ Yes ☐ No

Carers health:_____

Frequency of contact with client (inc phone) ☐ Daily ☐ 1x per wk ☐ 2-3x per wk ☐ Variable

Type of help provided by carer:_____

Carers perception of major issues:

Advanced Health Directive /EPA /EPG: ☐ Yes, please provide details: ☐ No

Personal Alarm: ☐ Yes ☐ No DVA: ☐ Yes – circle type: *White* /*Gold* ☐ No DVA

Previous ACAT assessment: ☐ Yes - assessment date: ____ /_____ /_____ ☐ No ACAT ☐ TCP

| Approval type | ☐ Residential | ☐ High Care ☐ Low Care | ☐ Residential Respite | ☐ High Care ☐ Low Care | ☐ Home Care Packages | ☐ Level 1 + 2 ☐ Level 3 + 4 |
|---|---|---|---|---|---|---|

| Service provider: | Service type/care provided: |
|---|---|
| Comments | |

**If any concern, please refer to Social Worker** **Referral completed:** ❑ **Yes** ❑ **No**

| | | | |
|---|---|---|---|
| Hospital _____ | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| **DTU Interdisciplinary Screen** | | Telephone | |

| **Current Observations / System Review** | | Initial | Date |
|---|---|---|---|
| Pain | ☐ No ☐ Yes | Details: | |
| Dizziness | ☐ No ☐ Yes | Details: | |
| Short breath on exertion/rest | ☐ No ☐ Yes | Details: | |
| Visual impairment | ☐ No ☐ Yes | Details : | |
| Glasses | ☐ No ☐ Yes | Eyes tested in last 2yrs ☐ No ☐ Yes | |
| Hearing impairment | ☐ No ☐ Yes | Details: | |
| Smoking | ☐ Never ☐ Quit date:___ /____ /____ | Consumption: | |
| Alcohol | ☐ Never ☐ Quit date: / / | Consumption: type: | |
| Sleep/rest pattern | Problem falling asleep ☐ Yes ☐ No<br>Problem staying asleep ☐ Yes ☐ No<br>Sleeping tablets taken? ☐ Yes ☐ No If *'yes'* please specify below:<br>Type: How often: | | |
| Comments | | | |

| **Medication** | | Initial | Date |
|---|---|---|---|
| Administration | ☐ Self ☐ Supervised ☐ Assistance, please specify: | | |
| Concern expressed about compliance | ☐ No ☐ Yes | | |
| Aids/support used | ☐ Webster/blister pack ☐ Dosette Box ☐ Boxes/bottles ☐ Timer | | |
| 5 or more medications | ☐ No ☐ Yes | | |
| Difficulties swallowing medication | ☐ No ☐ Yes | | |
| **If any concern, action taken: Advised visit GP❑ OT referral ❑ SW referral ❑ discuss in team meeting ❑** | | | |

| **Communication & Swallowing** | Initial | Date |
|---|---|---|
| Do you have any difficulties swallowing food, fluids or medications? e.g. coughing, choking. | ☐ Yes ☐ No | |
| Have you noticed any changes to your speech/voice?<br>e.g. less clear, more effortful, difficulty thinking of or saying words. | ☐ Yes ☐ No | |
| Are you having difficulty understanding language or writing?<br>e.g. difficulty making sense of a sentence, conversation or written information. | ☐ Yes ☐ No | |
| **If any concern please refer to Speech Pathologist** | **Referral completed? ❑ Yes ❑ No** | |

| **Mobility** | | Initial | Date |
|---|---|---|---|
| Transfers | ☐ Independent ☐ Requires assistance | Aids: | |
| Indoor ambulation | ☐ Independent ☐ Requires assistance | Aids: | |
| Outdoor ambulation | ☐ Independent ☐ Requires assistance | Aids: | |
| Stairs | ☐ Independent ☐ Requires assistance | Aids: | |
| **If any concern please refer to Physio** | **Referral completed? ❑ Yes ❑ No** | | |

| | | | |
|---|---|---|---|
| Hospital _____ | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| **DTU Interdisciplinary Screen** | | Telephone | |

| **FROP- Com Falls Screen** | | Initial | Date |
|---|---|---|---|
| Falls History | How many falls in last 12months?<br>☐ **0 =** None ☐ **1 =** Fall ☐ **2 =** 2 Falls ☐ **3 =** 3 or more falls | **Score** ____ | |
| Function ADL Status | Prior to this fall, how much assistance was required for IADLs? e.g. cooking, housework, laundry<br>☐ **0 =** None, completely independent ☐ **1 =** Supervision<br>☐ **2 =** Some assistance ☐ **3 =** Completely dependent | ____ | |
| Balance | Observe the client walk a few meters, turn and sit down. Client is to use walking aid if normally used. Score 3 if unable to walk due to injury.<br>☐ **0 =** Steady☐ **1 =** Unsteady but safe☐ **2 =** unsteady, supervision<br>☐ **3 =** Needs hands on assistance | ____ | |
| Screen Score | Please circle score total on chart below | | |

| Total Score | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|---|
| Grading of falls Risk | **0 - 3 Low Risk** | | | | **4 - 9 High Risk** | | | | | |

**If score of >3, liaise with PT/OT re appropriate action/referral.** **PT/OT Referral completed? ☐ Yes ☐ No**

| **Home Environment** | Initial | Date |
|---|---|---|
| Do you have any difficulty getting in/out of the entrances of your home? ☐ No ☐ Yes | | |
| Do you have any handrails in your home? ☐ No ☐ Yes | | |
| Do you have any difficulty to manage in the shower or toilet? ☐ No ☐ Yes | | |
| Are you having any other difficulties getting on/off bed/chair in your home? ☐ No ☐ Yes | | |
| Comments: | | |

**If any concern, please refer to OT** **Referral completed? ❑ Yes ❑ No**

| **Cognition** | Initial | Date |
|---|---|---|
| Documented cognitive Impairment? ☐ Yes ☐ No If *'yes'* please provide details: | | |

| | | |
|---|---|---|
| MMSE: / 30 Date: | GDS: Date: | AMTS: Date: |

Recent change in cognitive status? ☐ Yes ☐ No Self/carer reported cognitive problems? ☐ Yes ☐ No

Mental health issues, previous/current

**Referral to Memory Clinic completed? ❑ Yes ❑ No** **Discussed with GP/consultant? ❑ Yes ❑ No**

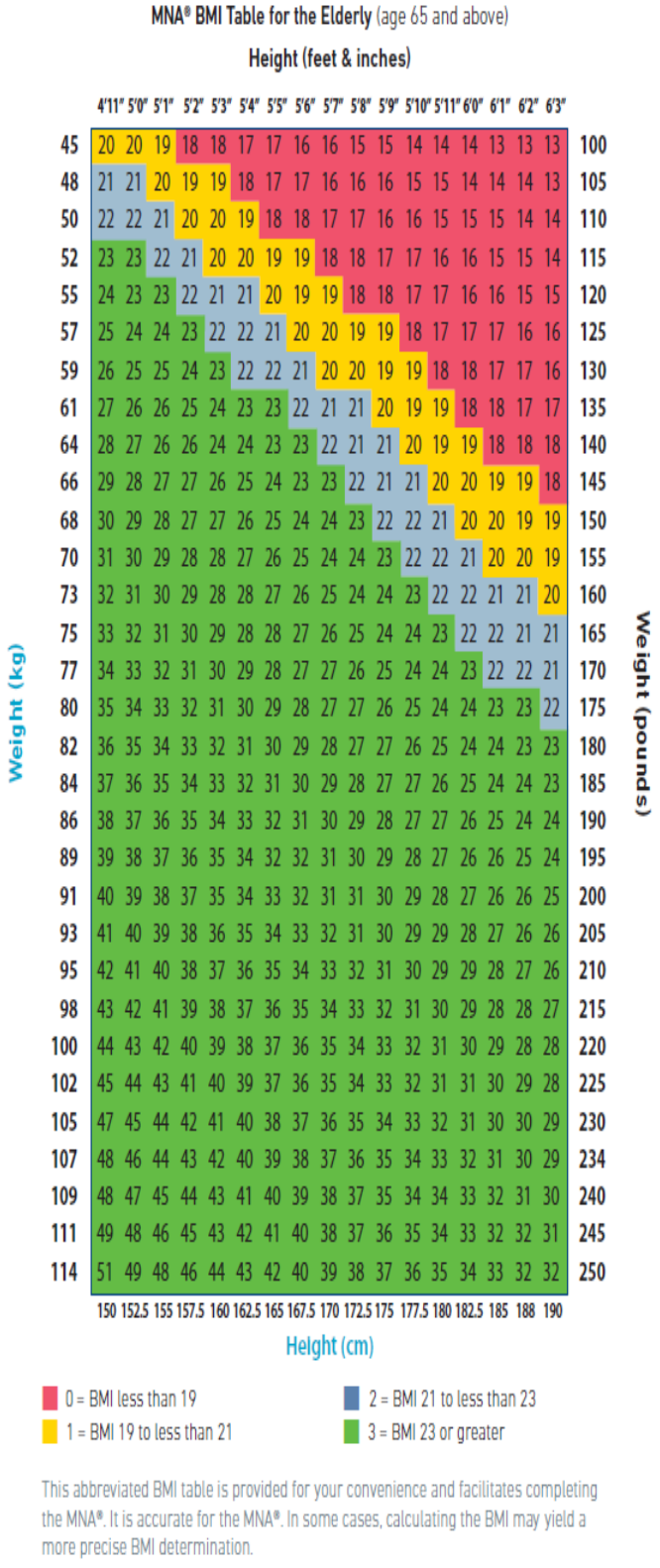
| **Continence** | Initial | Date |
|---|---|---|

| | | | |
|---|---|---|---|
| Urinary incontinence | ☐ No ☐ Yes | Continence aids used | ☐ No ☐ Yes details: |
| Faecal incontinence | ☐ No ☐ Yes | Constipation | ☐ No ☐ Yes |
| Comments | | | |

**If any concern, please refer to: Nursing coordinator ❑ Continence advisor ❑ discuss in team meeting ❑**

| | | | |
|---|---|---|---|
| Hospital _____<br>**DTU Interdisciplinary Screen** | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| | | Telephone | |

| **Mini Nutritional Assessment (MNA)** | **Score** |
|---|---|
| **A** Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?<br>0 = severe loss of appetite<br>1 = moderate loss of appetite<br>2 = no loss of appetite | |
| **B** Weight loss during the last 3 months<br>0 = weight loss greater than 3 kg (6.6 lbs)<br>1 = does not know<br>2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)<br>3 = no weight loss | |
| **C** Mobility<br>0 = bed or chair bound<br>1 = able to get out of bed/char but does not go out<br>2 = goes out | |
| **D** Has suffered psychological stress or acute disease in the past 3 months?<br>0 = yes 2 = no | |
| **E** Neuropsychological problems<br>0 = severe dementia or depression<br>1 = mild dementia<br>2 = no psychological problems | |
| **F**. Body mass index (BMI)(weight in kg)/(height in $m^2$)<br>0 = BMI less than 19<br>1 = BMI 19 to less than 21<br>2 = BMI 21 to less than 23<br>3 = BMI 23 or greater | |
| **Screening Score** | **Total** |
| **12 – 14**<br>Normal – no further action required<br><br>**8 – 11**<br>At risk of malnutrition – refer to dietitian<br><br>**0 – 7**<br>Malnourished – refer to dietitian | |




| Name | Profession | Signature | Date |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
| Hospital _____ | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| **DTU Interdisciplinary Screen** | | Telephone | |

## DAY THERAPY UNIT NURSING OBSERVATION / ASSESSMENT FORM

**Date:** **Name of Nurse:** **Consultant:**

**Clinic :** Geriatric ❑ Falls ❑ Memory ❑ Parkinson's ❑ Continence ❑
Stroke ❑ Other:

| **Observations** | | | | **(Record/Tick as appropriate)** |
|---|---|---|---|---|
| | **1st visit** | **Follow up** | **Follow up** | **Follow up** |
| **Date** | | | | |
| **Weight** | | | | |
| **Height** | | | | |
| **BMI** | | | | |
| **BP Lying** | | | | |
| **BP Standing (1minute)** | | | | |
| **BP Standing (1minute)** | | | | |
| **BP Standing (1minute)** | | | | |
| **BP Symptomatic?** | Yes ❑ No ❑ | Yes ❑ No ❑ | Yes ❑ No ❑ | Yes ❑ No ❑ |
| **Temperature** | | | | |
| **Pulse** | | | | |
| **$0_2$ Sats** | | | | |
| **Epworth Sleepiness Scale** | | | | |
| **BSL** | | | | |
| **Urinalysis** | | | | |
| **Amount voided** | | | | |
| **Post Void Residual** | | | | |
| **ECG** | | | | |
| **Nutrition (MNA)** | 12 points or greater-Normal –not at risk -no need to complete assessment<br>11 points or below-possible malnutrition – refer for Dietitian assessment **Score: ____** | | | |
| **❑ MMSE ❑ AMTS** | | | | |
| **GDS** | | | | |
| **Skin lesions/pressure areas** | | | | |
| **Comments:** | | | | |
| **Date:** | **Name:** | | **Signature:** | |
| **Comments** | | | | |
| **Date:** | **Name:** | | **Signature:** | |
| **Comments** | | | | |
| **Date:** | **Name:** | | **Signature:** | |

| | | | |
|---|---|---|---|
| Hospital _____ | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| **DTU Interdisciplinary Screen** | | Telephone | |

## Medication

**Pharmacy details**: **Phone:**

**Allergies:**

**1st visit** **Date:**

| Medication name | Dose | Frequency | Medication name | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
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## Medication

**Follow up** **Date:**

| Medication name | Dose | Frequency | Medication name | Dose | Frequency |
|---|---|---|---|---|---|
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## Medication

**Follow up** **Date:**

| Medication name | Dose | Frequency | Medication name | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
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| | | | |
|---|---|---|---|
| Hospital _____ | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| **DTU Interdisciplinary Screen** | | Telephone | |

| **Lawtons IADLs** | | | | |
|---|---|---|---|---|
| **Item** | **Score** | **Task** | **Admission Score** | **Discharge Score** |
| 1 Telephone | 1<br>2<br>3<br>4 | Cannot use telephone at all<br>Can answer telephone but cannot dial<br>Can dial a few well-known numbers. Includes dialling only numbers that can be speed dialled.<br>Can operates telephone on own initiative - looks up and dials numbers etc. Includes use of TTY machine if no other assistance required. | | |
| 2 Shopping (do not include transport here –rate at item 6) | 1<br>2<br>3<br>4 | Completely unable to shop<br>Needs to be accompanied on any shopping trip<br>Can shop independently for small purchases<br>Can take care of all shopping needs independently | | |
| 3 Food preparation | 1<br>2<br>3<br>4 | Needs to have meals prepared and served<br>Can heat and serve prepared meals, or can prepare meals but not does maintain adequate diet (see note below)<br>Can prepare adequate meals if supplied with ingredients<br>Can plan, prepare, serve adequate meals independently | | |
| 4 Housekeeping | 1<br>2<br>3<br>4 | Cannot participate in any housekeeping tasks<br>Can perform some light daily tasks but not at a level necessary to maintain an acceptable standards of cleanliness (see note below)<br>Can perform light daily tasks eg dishwashing, dusting<br>Can maintain house independently | | |
| 5 Laundry | 1<br>2<br>3<br>4 | All laundry must be done by others<br>Can launder small items - rinses socks, stockings etc<br>Can do personal laundry but needs help with heavier items such as bedding and towels (excludes ironing)<br>Can do personal laundry completely | | |
| 6 Mode of transportation | 1<br>2<br>3<br>4 | Requires manual assistance from more than 1 person or does not travel at all<br>Travel limited to taxi or automobile with assistance of one other person<br>Can travel on public transportation when assisted or accompanied by another<br>Can travel independently on public transportation or can drive own car. Includes arranging own travel via taxi but not otherwise using public transport. | | |
| 7 Responsibility for own medications | 1<br>2<br>3 | Is not capable of dispensing own medication<br>Can take responsibility if medication is prepared in advance in separate dosages<br>Can take responsibility for taking medications in correct dosage at correct time | | |
| 8 Ability to handle finances | 1<br>2<br>3 | Incapable of handling money<br>Can manage day-to-day purchases, but needs help with banking, major purchases etc<br>Can manage financial matters independently (budgets, writes cheques, pays rent, bills, goes to bank), collects and keeps track of income | | |

| | | | |
|---|---|---|---|
| Hospital _____ | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| **DTU Interdisciplinary Screen** | | Telephone | |

| **GDS – 15 Geriatric Depression Scale** | | |
|---|---|---|
| | **No** | **Yes** |
| 1. Are you basically satisfied with your life? | 1 | 0 |
| 2. Have you dropped many of your activities and interests? | 0 | 1 |
| 3. Do you feel that your life is empty? | 0 | 1 |
| 4. Do you often get bored? | 0 | 1 |
| 5. Are you in good spirits most of the time? | 1 | 0 |
| 6. Are you afraid that something bad is going to happen to you? | 0 | 1 |
| 7. Do you feel happy most of the time? | 1 | 0 |
| 8. Do you often feel helpless? | 0 | 1 |
| 9. Do you prefer to stay at home, rather than going out and doing things? | 0 | 1 |
| 10. Do you feel that you have more problems with memory than most? | 0 | 1 |
| 11. Do you think it is wonderful to be alive now? | 1 | 0 |
| 12. Do you feel worthless the way you are now? | 0 | 1 |
| 13. Do you feel full of energy? | 1 | 0 |
| 14. Do you feel that your situation is hopeless? | 0 | 1 |
| 15. Do you think that most people are better off than you are? | 0 | 1 |
| **TOTAL** | | |

| **AMTS - Abbreviated Mental Test Score** | |
|---|---|
| | **Score** |
| What is your age? (1 point) | |
| What is the time to the nearest hour? (1 point) | |
| Give the patient an address, and ask him or her to repeat it at the end of the test.(1 point) | |
| What is the year? (1 point) | |
| What is the name of the hospital or number of the residence where the patient is situated? (1 point) | |
| Can the patient recognize two persons (the doctor, nurse, home help, etc.)? (1 point) | |
| What is your date of birth? (day and month sufficient) (1 point) | |
| In what year did World War 1 begin? (1 point) (other dates can be used, with a preference for dates some time in the past.) | |
| Name the present monarch/dictator/prime minister/president. (1 point) (Alternatively, the question "When did you come to [this country]? " has been suggested) | |
| Count backwards from 20 down to 1. (1 point) | |
| **TOTAL** | |

| | | | |
|---|---|---|---|
| Hospital _____ | Surname | UMRN/MRN | |
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## MMSE

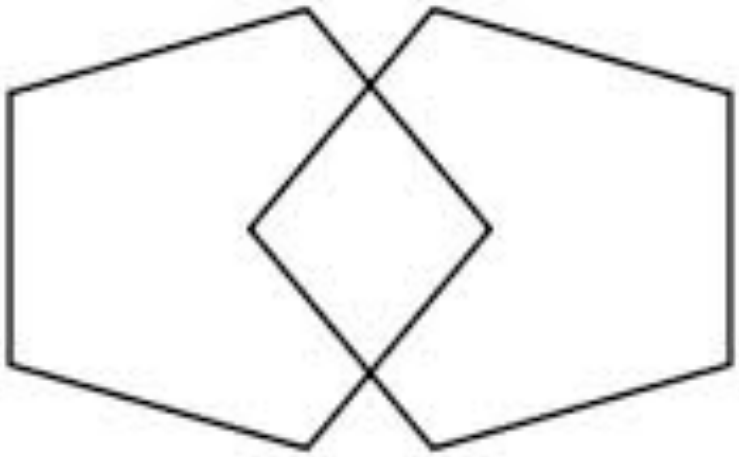
| | | | |
|---|---|---|---|
| 1. Year | ❑ 1 | 13. Word 1_____; Word 2 _____; Word 3 _____ | ❑ 3 |
| 2. Season | ❑ 1 | 12. D L R O W | ❑ 5 |
| 3. Month | ❑ 1 | 13. Word 1_____; Word 2 _____; Word 3 _____ | ❑ 3 |
| 4. Today's date | ❑ 1 | 14. Wristwatch | ❑ 1 |
| 5. Day of the week | ❑ 1 | 15. Pencil | ❑ 1 |
| 6. Country | ❑ 1 | 16. No if's, and's or but's | ❑ 1 |
| 7. State | ❑ 1 | 17. Subject closes eyes | ❑ 1 |
| | | 18. Take paper in correct hand ❑ | |
| 8. City | ❑ 1 | Folds it in half ❑ | ❑ 3 |
| | | Puts it on the floor ❑ | |
| 9. Place | ❑ 1 | 19. Sentence | ❑ 1 |
| 10. Floor of building | ❑ 1 | 20. 4-sided figure in two 5-sided figures | ❑ 1 |

**TOTAL SCORE _____**

DATE Name Designation Signature

| | | | |
|---|---|---|---|
| Hospital _____<br>**DTU Interdisciplinary Screen** | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| | | Telephone | |

# CLOSE YOUR EYES



| | | | |
|---|---|---|---|
| Hospital _____<br>**DTU Interdisciplinary Screen** | Surname | UMRN/MRN | |
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| | | Telephone | |

## The Clock Drawing Test

Patient should be asked to:

- Draw a large circle
- Write in all the numbers in the correct positions
- Draw hands to indicate 10 minutes pass 11 in the correct position

**Scoring:**

The Alzheimer's disease cooperative scoring system is based on a score of five points.

1. Point for the clock circle
2. Point for all the numbers being in the correct order
3. Point for the numbers being in the right place on the clock face
4. Point for the tow hands of the clock
5. Point for the correct time

A normal score is four or five points.

| | | | |
|---|---|---|---|
| Hospital _____<br>**DTU Interdisciplinary Screen** | Surname | UMRN/MRN | |
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| | | Telephone | |

| **DAY THERAPY UNIT CARE PLAN** | |
|---|---|
| Admission Date: | Initial Assessment Date: |
| Consultant: | |
| I (or support person) understand and agree to this plan: | Yes ☐ No ☐ |
| I (or support person) have a copy of the plan: | Yes ☐ No ☐ |
| I agree to have this plan shared with my GP: | Yes ☐ No ☐ |

**Who is involved in the care plan?**

Client ☐ Carer ☐ Geriatrician ☐ Nursing ☐ PT ☐ OT ☐

SP ☐ Diet ☐ SW ☐ C Psych ☐ Continence ☐ Podiatry ☐

**Care Plan**

| **What I would like to improve?** (Area of concern) | **What I would like to achieve?** (Agreed Goals) | **Agreed action** to be taken | **By whom & when** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Other Considerations**

| | | |
|---|---|---|
| | | |
| Plan developed: | Planned Review date: | Copy sent to GP: Yes q No q |
| This information collected by: | | |

| Name: | Profession: | Signature: | Date: |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
| Hospital _____<br>**DTU Interdisciplinary Screen** | Surname | UMRN/MRN | |
| | Given Names | DOB | Gender |
| | Address | | Post Code |
| | | Telephone | |

| **DTU Care Plan Review** | | | |
|---|---|---|---|
| **Agreed Goals** (refer to original Care Plan) | **Progress** | | **Goals Achieved & Date** |
| | | | |
| | | | |
| | | | |
| This information collected by: | | | |
| Name: | Profession: | Signature: | Date: |

| **DTU Care Plan Review** | | | |
|---|---|---|---|
| **Agreed Goals** (refer to original Care Plan) | **Progress** | | **Goals Achieved & Date** |
| | | | |
| | | | |
| | | | |
| This information collected by: | | | |
| Name: | Profession: | Signature: | Date: |

Government of **Western Australia**
Department of **Health**

# Glossary

**Abbreviated Mental Test Score (AMTS)**
The AMTS is a 10-item tool designed to screen for cognitive impairment, with a score of 7 or less out of 10 indicating cognitive impairment.

**Aged Care Assessment Team (ACAT)**
ACATS help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance. ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or community care services.

**Australian Modified Lawton's Instrumental Activities of Daily Living (IADL) Scale**
The Australian Modified Lawton's IADL Scale assesses the complex ADL skills necessary for living and functioning in the community independently in relation to instrumental tasks such as shopping, cleaning, cooking, managing finances. It is designed to be a tool to enable benchmarking rehabilitation outcomes across services, in addition to other existing patient, discipline or service specific outcome measures.

**Clinicians**
A clinician is a health care provider who is involved in the delivery of health care to a patient and maybe be one of the following: medical professional, allied health professional, nursing professional, and therapy aide.
(*This is not an exhaustive list)*

**Care Coordination Team (CCT)**
CCT is a multidisciplinary team providing comprehensive assessments of patients and care coordination within the Emergency Department in order to facilitate discharge planning. This includes the allocation of hospital and community resources and the timely and efficient provision of services to meet patients' needs.

**Commonwealth Home and Community Care (HACC) Program**
The Commonwealth HACC Program provides 19 basic maintenance, support and care services to assist people to remain in the community. The services focus on supporting different areas of need that an individual may have due to a limitation in their ability to undertake tasks of daily living.

**Community Physiotherapy Service (CPS)**
CPS offers community based rehabilitation, incorporating physical activity and education programs for adults with chronic conditions. Programs are designed to maximise functional ability and minimise the impact of chronic disease and related secondary complications.

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**De Morton Mobility Index (DEMMI)**
The DEMMI, De Morton Mobility Index is an advanced instrument for accurately measuring and monitoring changes in mobility for all older adults. It has been validated to be used across health care settings, including the community.

**Geriatric Depression Scale**
The Geriatric Depression Scale is used to identify depression in older people in hospital, aged care home and community settings. The 15 item version is most widely used with self report or informant report, and takes 5/10 minutes to complete.

**Geriatric Syndromes**
Geriatric syndromes describe the unique features of common health conditions in older people that do not fit into discrete disease categories. These conditions include delirium (acute confusion), falls, incontinence, and frailty. They are highly prevalent in older people. Their effect on quality of life and disability is substantial. Multiple underlying factors, involving multiple organ systems, tend to contribute to geriatric syndromes. Frequently the primary symptom is not related to the specific pathological condition underlying the change in health status.

**Mini-Mental State Examination (MMSE)**
MMSE is a brief 30-point questionnaire test that is used to screen for cognitive impairment and dementia. Any score greater than or equal to 25 points (out of 30) indicates a normal cognition. Below this, scores can indicate severe (≤9 points), moderate (10-18 points) or mild (19-24 points) cognitive impairment.

**Rehabilitation in the Home (RITH)**
RITH provides short to medium term, hospital-substitution allied health therapy, allowing early hospital discharge, assistance in the hospital to home transition and prevention of readmission to hospital. RITH is designed to improve patient flow and patient outcomes as well as support demand management, by creating virtual beds in the community.

**Timed Up and Go Test (TUG)**
TUG is a simple test used to assess a person's mobility and requires both static and dynamic balance, using the time that a person takes to rise from a chair, walk three metres, turn around, walk back to the chair, and sit down. During the test, the person is expected to wear their regular footwear and use any mobility aids that they would normally require.

This document can be made available in alternative formats on request for a person with a disability.