MSK Rehab Definitions Framework - Hip Fractures
Self assessment Survey – Inpatient Rehab

In response to a changing rehab landscape in which rehabilitation is offered in many different settings with variations in service scope, the GTA Rehab Network has recognized the need to clearly articulate the essential components of publicly-funded rehabilitation and to develop definitions for hip fractures and other population-specific rehab services, incorporating evidence-based standards of practice where available.

The overall intent of the MSK Rehab Definitions Framework for Hip Fractures is to:

- Define and promote consistency in hip fracture rehab care across different care settings
- Increase clarity for patients, families and referrers through the use of consistent terminology
- Establish a standard of care to enable targeted discussions regarding system planning, resourcing of services and performance measurement in rehab to ensure the availability of quality rehabilitation interventions across settings.

The MSK Rehab Definitions Framework for Hip Fractures is attached for your reference.

ACTION REQUESTED:
As part of this initiative, we are asking your clinical team to complete the **Inpatient Rehab** self assessment survey

PURPOSE OF THE SELF ASSESSMENT SURVEYS:
The GTA Rehab Network has developed self assessment surveys that organizations can use to evaluate the capacity of their hip fracture rehab services to meet the definitions in the MSK Rehab Definitions Framework for Hip Fractures. The self assessment surveys also provide a mechanism through which organizations can:

- Identify opportunities for quality improvement initiatives
- Improve the delivery of rehab services for hip fractures
- Advocate for resources to promote consistency and equitable access to rehab services for hip fractures.

INSTRUCTIONS:

- Please use the following self assessment survey to rate the provision of rehab services offered by your organization to patients with hip fractures who were *admitted within the past 6 months*.
- A combination of questions is used: (1) A rating scale based on the guidelines below. **NB: Check only one rating for each standard!!**
  Fully Met: The standard is met at least 80% of the time
  Partially Met: The standard is met 40 – 79% of the time
  Not Met: The standard is met less than 40% of the time
  (2) Yes/No questions. These do not require ratings.
- If the standard is not fully met, please explain the reasons that account for difficulties in meeting the standard fully.

HIP FRACTURE SELF ASSESSMENT SURVEY - INPATIENT REHAB
MIXED OR DEDICATED POPULATION INPATIENT REHABILITATION UNIT

Name of Organization: ______________________________ **Name of Service/Program:** ____
Primary Contact (name/telephone): ______________________________

	Standard		Rating Fully met (80% of time) (✓)	Rating Partially met (40 – 79% of time) (✓)	Rating Not met (< 40% of time) (✓)	If standard not fully met, provide explanation.
Services Provided	• Care is provided by a coordinated, interprofessional team specialized in geriatrics.					
	• The core team[1] includes all of the following professionals:					
	Clinical Dietitian	Yes No				
	Discharge planning role[2]	Yes No				
	Nurse	Yes No				
	Occupational Therapist	Yes No				
	Pharmacist	Yes No				
	Physiotherapist	Yes No				
	Physiatrist and/or Geriatrician	Yes No				
	Social Worker	Yes No				
	• Where a physician or a geriatrician is not available on the core team, a mechanism is in place to access the expertise of these professionals through consultation (e.g. RGP).					
	• Consultation[3] is available from all of the following:					
	Chaplain/pastoral care provider	Yes No				
	Chiropodist	Yes No				
	Geriatric Psychiatrist	Yes No				
	Physician specialized in internal medicine	Yes No				
	Specialist in gerontology[4]					
	Speech Language Pathologist	Yes No				
	Urologist	Yes No				
	Wound care specialist	Yes No				

[1] Core team refers to the team members who are essential, actively involved in the assessment and treatment of MSK patients on the unit. In acute care, although team members collaborate closely, they may not participate regularly in team rounds due to the nature of this setting.
[2] Discharge planning role may be filled by a social worker, discharge planner/coordinator, patient flow coordinator, etc.
[3] Consultation is expected to be available within 24 hours in acute care and within 48 hours in rehab.
[4] Specialist in gerontology may be filled by an advance practice nurse, nurse practitioner specialized in gerontology, etc.

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Services Provided (cont.)	• ***For High Tolerance, Short Duration Rehabilitation (HTSD) Programs:*** An intensive rehab program is provided with both of the following: A minimum of 2 hours of per day of individualized therapy offered between OT and PT.	Yes No				
	7 days a week of individualized[5] therapeutic activity (which can be provided between OT, PT, OTA/PTA, Nursing, etc.).	Yes No				
	• ***For Low Tolerance Long Duration (LTLD) Rehabilitation Programs:*** A slower paced program is provided with both of the following: A minimum of 30 minutes per day	Yes No				
	5-7 days a week of individualized[5] therapeutic activity (which can be provided between OT, PT, OTA/PTA, Nursing, etc.).	Yes No				
	• For both HTSD and LTLD programs, at a minimum, the staffing ratio is sufficient to support a minimum of 2 hours of individualized[5] therapeutic activity between the OT and PT professions (including OTA/PTA/other support staff), 7 days a week.					
	• Services may be supplemented by OTA/PTA/CDA/PSW/RA under the direct supervision of respective health care professionals (e.g. OT directing OTA) as legislated by their respective colleges. Assistants can provide support to the therapists, but the overall care is directed by the regulated health professional and the OTA/PTA/CDA/PSW/RA usually does not exceed 60% of therapy time.					
	• Where a client has more than one rehab need (e.g. ABI & MSK) there is a mechanism in place to cross consult to another rehab service to acquire expertise in other rehab areas.					

[5] Individualized therapeutic activity refers to patient-centred, goal-specific therapy which does not necessarily need to be delivered in a one-to-one setting.

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Specialization	• More than one ***MSK related*** population is served in this program (e.g. fracture, arthritis). *If yes, please indicate which populations are served in the comments section.*	Yes No				
	• More than one ***non-MSK related*** population is served in this program (e.g. stroke, pulmonary). *If yes, please indicate which populations are served in the comments section.*	Yes No				
	• ***For both mixed and dedicated population programs:*** There is a dedicated MSK/Ortho interprofessional team for MSK/Ortho patients.					
	• ***For both mixed and dedicated population programs:*** The dedicated MSK/Ortho team has access to skills/training to develop and maintain the necessary skills and knowledge base.					
Specialization (cont.)	• There is a critical mass of 50 cases/year to support the development and maintenance of clinical expertise of all staff.					
	• ***For mixed population programs only:*** Beds are geographically clustered with other MSK/ortho patients.					❑N/A
	• All core and consult team members have expertise in senior focused care, including all of the following components:					
	Appropriate communication with cognitively impaired persons	Yes No				
	A team approach to assess and implement a safe environment	Yes No				
	Ability to assess and support patients' informed decision making	Yes No				
	• All core team members have expertise in management of pre-morbid conditions (e.g. cardiac, dementia).					
	• The core team has established competency in treating patients with hip fractures; specifically, they have competency in each of the following areas:					
	Pain management	Yes No				
	Non-pharmacological and pharmacological sleep	Yes No				

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	management					
	Bladder and bowel care and re-training	Yes No				
	Falls prevention	Yes No				
	Ability to identify each of the following and understand the difference between them: delirium (e.g. with CAM), dementia (e.g. with MMSE), and depression (e.g. with GDS)	Yes No				
	Ability to appropriately manage delirium, dementia, and depression.	Yes No				
	Assessment and incorporation of the individual's unique needs and interests (i.e. personhood)	Yes No				
	Preventative daily care (e.g. mobility, positioning, nutrition, hydration)	Yes No				
Differential Criteria	• The therapy levels indicated in this framework are not interpreted as admission criteria, but are rather used as an indication of the minimum amount of therapy the program should be able to provide.					
	• Determination of rehab need is patient-centred rather than driven by perceived length of stay or level of tolerance.					
	• Patients from all types of pre-morbid living situations (e.g. home, long term care facility) are considered equally with regards to decision making for inpatient rehab admission.					
	• All patients with mild to moderate cognitive impairment are considered equally with those who are cognitively intact with regards to decision making for inpatient rehab.					
	• Patients with severe cognitive impairment are considered for inpatient rehab with consideration for weight bearing status and pre-morbid function.					
	• Patients are only referred to transitional care as a temporary destination in rare circumstances when they are expected to be 100% non weight bearing for a period of 6 weeks or more.					
	• Once a patient is admitted to inpatient rehab, every effort is made to					

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	ensure consistency of the clinical team. If a patient's rehab needs change during the course of their stay, those needs are met by the current clinical team without requiring the patient to change beds, units, programs or buildings whenever possible.					
	• Based on available evidence, the timeframe between surgery and admission to inpatient rehab is no more than 15 days; however, ideally this timeframe is as soon as possible.					
Typical Duration	• Length of stay is not constrained by a maximum duration, but is linked to the patient's needs and goals.					
Key Activities/ Nature of Service	• Regular team meetings/conferences are held.					
	• Patients and families are encouraged to participate in interprofessional family meetings.					
	• A mechanism is in place for communication of goals between patient/family and the rehab team.					
	• There are established mechanisms for communication, collaboration and transfer of information between professions to maximize patient outcomes.					
	• A coordinated team approach is used to maximize a person's abilities (e.g. therapy staff assess a patient's ability and nursing staff reinforce treatment strategies).					
	• All of the following activities are provided:					
	Promotion of abilities with care focused on maximizing self care	Yes No				
	Preventative daily care (e.g. mobility, positioning, nutrition, hydration)	Yes No				
	Early mobility, including integration of mobility, strength and balance	Yes No				
	Maximizing of functional potential (e.g. ADL)	Yes No				
	Home safety	Yes No				
	Thorough cognitive assessment to rule out neurological	Yes No				

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Key Activities / Nature of Service (cont.)	sequelae from the fall					
	• As part of hip fracture care, a delirium management program is provided which includes all of the following components:					
	Use of a standardized screening tool for delirium (e.g. CAM)	Yes No				
	Identification of possible causes of/contributors to delirium	Yes No				
	Education provided to the family on delirium	Yes No				
	Intervention/strategies to minimize delirium and maximize functional and cognitive gains.	Yes No				
	• Discharge planning occurs early on in the inpatient rehab process.					
	• All patients discharged from inpatient rehab have a plan in place for ongoing rehab and care management (e.g. outpatient rehab, CCAC rehab, private therapy).					
	• Patients are screened for falls risk based on personal and environmental risk factors.					
	• Those at increased risk are offered multiple interventions ***OR*** are referred to a falls prevention program or lifestyle management program (e.g. Arthritis society, YMCA) with their caregiver, if needed. These interventions or programs address:					
	Osteoporosis management	Yes No				
	Exercise and balance re-training	Yes No				
	Modification of falls risk factors/hazards	Yes No				
	Education re: falls prevention	Yes No				
	• Communication with both the patient's surgeon and family physician is established around the time of discharge to support continuity of care and the patient's long term osteoporosis management, falls prevention and rehabilitation plans.					
	• There is a mechanism in place to assess the patient/family's learning needs.					

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• Education on all of the following topics is available and reviewed with patients/families as appropriate:					
Caregiver training	Yes No				
Safe activity resumption	Yes No				
Delirium management	Yes No				
Medication	Yes No				
Mobility	Yes No				
Expected progress	Yes No				
Pain management	Yes No				
Sources of help	Yes No				
Falls prevention/management	Yes No				
Osteoporosis management	Yes No				
Anti-coagulation	Yes No				
• Appropriate outcome measures are used to document progress and recovery and guide treatment selection including					
Performance measures	Yes No				
Self-report measure	Yes No				
Clinical measures	Yes No				

Based on the above definitions, would you classify your unit as a Mixed or Dedicated Inpatient Rehab Program? □ Yes □ No

Comments:

Thank you for taking the time to complete the Inpatient Rehab Self Assessment Survey for Hip Fractures