Instructions for completing the Trauma Recovery and Rehabilitation Plan

Background

The *Trauma Recovery and Rehabilitation Plan* (the Plan) was developed for out of catchment trauma patients with complex discharge needs to facilitate their recovery closer to home. The following instructions have been developed to support clinicians use of *the Plan.* Completion of *the Plan* encourages a person-centered interdisciplinary approach to decision-making and planning by early documentation of a patient's demographics, relevant injuries and management for each of these injuries, ongoing rehabilitation needs, services the patient has been referred to and contact numbers of the treating teams.

It is recommended *the Plan* is led by an allocated key worker in the treating team and is completed collaboratively by members of the interprofessional team providing assessment and intervention to the person during their hospital admission. The document should be completed with the patient and reviewed and updated as the patient's needs change. It is recommended the document is used as a guide for clinical team discussions, updates and handovers. A copy of *the Plan* should be provided to the patient for their personal records. Clinicians from the treating team may wish to make contact to provide a more comprehensive profession-specific report to the respective clinician at the receiving site as part of clinical handover.

Please note: *The Plan* can be downloaded to your desktop or drive and used as an interactive PDF, or the standard version can be printed out and handwritten.

To provide feedback about the plan and instructions please contact
QldRehabilitationNetwork@health.qld.gov.au

Instructions

Section One – Demographics and current status

Admission date: **Estimated date ready for transfer/discharge:**
Previous transfers (locations and date):
Current location/ward: hospital and ward name or program/service
Treating team key contact details: list current treating team names, roles and contact numbers
Reason for admission: list of injuries, management plan, weight bearing status, review dates date of Injury
Relevant medical history: overview of relevant past and current medical history
Infectious precautions: examples may include MRSA, ESBL, VRE
Allergies: list of known allergies
Significant events/complications: include an overview of MET calls (including number of calls and details and dates), ICU admissions (including details and dates), special nursing requirements (including details and dates) and if the patient has a valid Acute Resuscitation Plan (ARP).

Section two - Social situation

Provide detail including living arrangements, support person details (name and relationship to patient), enduring Power of Attorney details (including name if possible), Advanced Health Directive details (including name if possible). Specify if the patient identifies as Aboriginal and/or Torres Strait Islander and outline if Indigenous Liaison/Health worker required. Specify the patient's preferred language and if an interpreter is required. Existing formal support services are also listed in this section including community services (e.g. personal care assistance, domestic assistance), residential care, general practitioner, and other support services the patient was accessing prior their hospital admission.

Finances: specify details of income e.g. employment, or government income support payments such as pensions or allowances.

Funding: outline details of known healthcare funding. Include claim numbers if known. Examples include Workers' compensation, Disability and Community Care Services, Centrelink, National Disability Insurance Scheme (NDIS), Department of Veteran Affairs, Private Health.

National Injury Insurance Scheme (NIISQ): outline if application has commenced for no-fault scheme for those who sustain eligible serious personal injuries in a motor vehicle accident in Queensland.

NDIS: new/eligible, details - date application commenced.

My Aged Care: yes, no, details - date application commenced.

Section three - Home environment

Type of dwelling: house, unit, high-set, low-set, two-story, other: granny flat, caravan, hostel, unit – specify level

Ownership: owner occupied, private rental, Dept of Housing property, other: border, visiting

Equipment and home modifications in place:

Number of steps into home:

Shower/toilet access: shower recess, bath, shower over bath, curtain, glass pivot door, sliding glass doors, location of toilet

Occupational Therapist home visit recommendations: as per form questions

Additional details: flag issues with external access – access from street, vehicle access, letterbox/bin external access/general layout – location of rooms, living area, kitchen, dining, laundry, bedrooms, outdoor living area.

Section four - Pre-admission function

Mobility: independent, standby assistance, assistance, assistive equipment used,

Transfers, balance: transfers (toilet/bed/chair), stairs, balance, falls history

Upper limb: describe impairment, sensation, co-ordination, functional use

Personal care/hygiene: feeding, dressing, bathing, toileting, hygiene

Instrumental ADLs (iADLs): specify patient's ability to complete tasks that require complex planning and thinking e.g. cooking, cleaning, laundry, managing finances

Continence: bowel, bladder control and management, assistive aids used

Medication management: independent, requires assistance, uses assistive aids (e.g. Webster Pack)

Work history: current and relevant work history, leave available and relevant education

Driving history: driving skills and experience, specify if drives automatic/manual vehicle

Cognition: outline reported previous memory and thinking skills

Sensory: specify issues with senses - hearing, vision, taste
Other: Add any relevant information for pre-admission function.

Section five - Current function

Mobility, transfers, balance: independent, standby assistance, assistance, assistive equipment use, transfers (toilet/bed/chair), stairs, balance, falls history.
Upper limb: describe impairment, sensation, co-ordination, functional use.
Personal care/hygiene: feeding, dressing, bathing, toileting, hygiene.
Instrumental ADLs (iADLs): specify patient's ability to complete tasks that require complex planning and thinking e.g., cooking, cleaning, laundry, managing finances.
Continence: bowel, bladder control and management, assistive aids used
Medication management: independent, requires assistance, uses assistive aids (e.g. Webster Pack)
Cognition: outline memory and thinking skills and results of standardised assessments completed during admission (e.g. Mini Mental State Examination, Post Traumatic Amnesia Scale).
Sensory: specify issues with senses - hearing, vision, taste
Nutrition: Weight: kg **Height:** cm
Swallowing difficulties/recommendations: *current diet* - NBM, regular diet, easy to chew diet, soft and bite sized, minced and moist diet, pureed diet. *Current fluids* – NBM, thin fluids, slightly thick fluids, mildly thick fluids, moderately thick fluids, extremely thick fluids. Swallowing difficulties and safe swallowing strategies.
Communication: describe speech/language/voice/fluency impairment
Wound management: skin integrity, surgical wounds, pressure injuries/areas, and wound care requirements
Mood: details of observed/reported expression and affect and results of standardised assessments
Pain management:
Other relevant details: for example, PICC, IVC, NGT, PEG, oxygen, Insulin

Section six - Recommendations

Rehabilitation Needs

Patient goals	For goal-setting guidelines, clinician and consumer resources (including consumer workbook) visit https://clinicalexcellence.qld.gov.au/resources/goal-setting-rehabilitation/clinicians
Specialist medical needs	Ongoing specialist investigation/intervention, complex/unstable medical/surgical condition, complex rehabilitation care coordination (e.g. Prosthetics, Acquired Brain Injury, Spinal Cord Injury, Pain management)
Number and types of disciplines	Physiotherapy, Occupational therapy, Social Work, Speech pathology Dietetics, Alcohol, Tobacco, and other Drug Services (ATODS), Chronic disease management, Exercise physiology, Hydrotherapy, Mental Health Neuropsychology, Orthotics, Podiatry, Prosthetics, Psychology, Stomal therapy Other:_____
Frequency of therapy	None, low- less than daily, moderate - daily therapy from at least 1 discipline, high - daily therapy from 2 or more disciplines, very high – daily therapy from 2 or more disciplines requiring > 1-person assist

Psychosocial complexity	Complex capacity/consent issues, QCAT/EPOA/Substitute decision maker issues, NDIS/NIISQ application, accommodation issues, other complex psychosocial barriers (e.g. refugee, domestic and family violence, complex mood, cognitive or behavioural issues requiring specialist input)
Equipment	None, basic (e.g. mobility aid, cushion, over toilet aid), specialised (e.g. prosthesis, hoist, customised aids, bariatric, communication aid/s, tracheostomy/ventilation)
Setting	**Specialised inpatient rehabilitation** See Rehabilitation services (health.qld.gov.au) (CSCFv3.2) for more information. **Level 5/6 Specialist rehabilitation** for complex patients with ABI and SCI but also covers other complex trauma, may have access to hydrotherapy and independent living unit **Level 4** – inpatient care provided by a team with skills in rehabilitation in a designated unit for patients with moderately complex care needs in acute or post-acute phases. May include access to leisure and/or diversional therapy programs **Geriatric Evaluation and Management** – multidimensional needs associated with ageing and frailty generally for people over the age of 65 or 55 for Aboriginal and Torres Strait Islander people. Although this may vary depending on the local service variation. **General inpatient rehabilitation** Level 3 – inpatient care (medical, nursing and allied health) to low-risk patients in acute or post-acute phase whose rehabilitation needs are not complex Level 2 – Inpatient care to medically stable patients with low rehabilitation needs. Provided in Multi-Purpose Health Centres by nursing and allied health staff. **Community/Primary Health** Specialist outpatient rehabilitation - high intensity, multidisciplinary rehabilitation, case management, outpatient department service, Acquired Brain Injury or Spinal Cord Injury program, Amputee program, single discipline General community-based therapy – low intensity therapy for medically stable patients in the home or at Community Health Centre. Focus on improving general function and independence. Community health, Musculoskeletal clinic, NGO/Private. Primary Health – general practitioner, nursing, chronic disease management and prevention Specialist outreach services – visiting specialist service or telehealth **Aged Care Services** Commonwealth programs accessed via My Aged Care - Residential Transition Care Program, Home based Transition Care Program, Home Care Package, Commonwealth Home Support Program, Residential care, Residential respite
Destination	• Acute ward

	• Inpatient specialist/complex rehabilitation unit (Spinal, Acquired Brain Injury, Burns, Geriatric Evaluation and Management) • Local hospital without specialist rehabilitation • Local hospital awaiting specialist rehabilitation • Local hospital not requiring specialist rehabilitation • Other in-patient rehabilitation • Own home without rehabilitation • Own home with rehabilitation • Residential care • Residential respite care • Residential Transition Care Program • Home based Transition Care Program • Home with Home Care Package • Home with Commonwealth Home Support Program • Primary Health • Specialist outreach • Specialist inreach • Other:
Additional details	• Any other information related to recommendations

Patient's preference: preference for rehabilitation
Patient consented to referral(s):
Patient suitable to participate in rehabilitation:
Patient ready to participate in rehabilitation:
Patient suitable and agreeable to telehealth: (includes hybrid options so in-person is supplemented by telehealth)
Referral(s) completed: Detail other referrals that have been completed.
Reason for variance if recommendations different to discharge plan:
Review/plan date:
Comments/plan:
Additional information: this can be any additional information related to the plan.
Completed by:
Information obtained via: patient, family member, treating team members.

Date sent:
Trauma Recovery Plan sent to: example - X Hospital, GP, patient.