Minimum standards of care for the person following amputation – Self-assessment tool

This self-assessment tool can be used by health services to evaluate their existing service provision and identify areas for improvement necessary to meet the expected standards of care in NSW as outlined in the Minimum Standards document.

Date of assessment: / / Name of person completing assessment: _____

Service name: _____ Service Location: _____

Standard S1: Care is coordinated, multispecialty and interdisciplinary across all phases

Element and rationale	Self-rating and your evidence	Action plan and timeframe
There are documented processes and structures that support interdisciplinary care to the person → Ensures the service is equipped with the correct resourcing of staff	Fully documented ○ ○ Not documented ○ Supporting evidence:	
There is regular communication between other clinical services involved in amputee care → Allows for seamless transfer of care	Regular ○ ○ None ○ Supporting evidence:	
Rehabilitation providers attend all pre-surgical amputation clinics → Allows the person to plan for the future and understand post-surgical care/ rehabilitation	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Outline the care journey and the role and function of specialty teams and desired outcomes for the person
- List and explain to the person the role of each specialty involved in their care

Standard S2: A comprehensive care plan is developed and updated throughout the care journey

Element and rationale	Self-rating and your evidence	Action plan and timeframe
There is regular communication between other clinical services involved in amputee care when developing the person's care plan → Ensures all areas of care are considered for the person	Regular ○ ○ None ○ Supporting evidence:	
The person is involved in developing their care plan prior to surgery (excluding unplanned amputations) → Prepares the person for post-surgery and allows for empowerment and involvement	Always ○ ○ Never ○ Supporting evidence:	
Care plans include a comprehensive biopsychosocial assessment as well as integrated and interdisciplinary actions → A comprehensive biopsychosocial assessment pre-surgery allows for a baseline measurement so improvement can be tracked throughout the journey	Always ○ ○ Never ○ Supporting evidence:	
Care plans are regularly reviewed and updated throughout the care journey → Assists in care planning in the future	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Consider the person's goals and priorities (e.g., what are their preferred activities) when developing a care plan
- Consider those involved (e.g., valued others) when planning care, preferences and needs of the person

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Standard S3: Counselling and psychological support is available across all stages of care

Element and rationale		Self-rating and your evidence	Action plan and timeframe
There is a documented assessment for psychological support as part of the care journey	→ Assessment and referral to speciality services is planned and coordinated along the care journey Allows for timely assessment and referral	Fully documented ○ ○ Not documented ○ Supporting evidence:	
Validated assessment tools are incorporated at key stages during the care journey	→ Best practice and evidence-based practice are incorporated into care plans by care teams	Always ○ ○ Never ○ Supporting evidence:	
Interventions are available for depression; anxiety, sexuality, substance abuse and pain across the care journey	→ Ensures that counselling and psychosocial support are integrated within the care journey Services are defined and networks are established to ensure effective coordination of care	Always ○ ○ Never ○ Supporting evidence:	
Referral pathways are defined and determined based on the needs of the person	→ Referral pathways support effective coordination of counselling and psychological support at all stages of the care journey	Always ○ ○ Never ○ Supporting evidence:	
A validated psycho-social assessment is conducted and issues are addressed at each phase of care	→ Any psychosocial issues identified can be addressed as part of the overall treatment plan and reviewed	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Screen people for depression, anxiety, sexual dysfunction, pain and risk of substance abuse at regular intervals
- Psychological, social and physical support is not only for the person – think about their valued others too

Standard S4: Referral is offered to a managed peer support program

Element and rationale		Self-rating and your evidence	Action plan and timeframe
There is a documented process for peer support program referral, either pre- or post-amputation	→ Provides the person with access to information and peer support to adjust emotionally	Fully documented ○ ○ Not documented ○ Supporting evidence:	

Tips for implementation:

- Document and monitor managed peer support program involvement in the person's care plan

Standard S5: Falls prevention and falls safety education is provided

Element and rationale	Self-rating and your evidence	Action plan and timeframe
There is a documented process allowing early application of rigid removable dressings in transtibial amputations, where there are no contraindications → Rigid removable dressings help protect the residual limb in the event of a fall	Fully documented ○ ○ Not documented ○ Supporting evidence:	
Each person is reviewed for the risk of falls and home safety → Helps the person feel that their home is safe and that any risks are identified and addressed	Always ○ ○ Never ○ Supporting evidence:	
The balance and falls prevention training program is accessed when required → Helps minimise the risk of falling	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Use a validated falls screening tool to help standardise reviews
- A guide to rigid removable dressings can be found in Appendix 2

Standard S6: Discharge planning and transfer of care arrangements occur with communication between all key stakeholders

Element and rationale	Self-rating and your evidence	Action plan and timeframe
There are documented processes for providing designated contact details at point of entry to service and follow-up pathway(s) → Continuity of care is associated with better health outcomes and satisfaction to the person	Fully documented ○ ○ Not documented ○ Supporting evidence:	
A contact person is named for the person being transferred to another service → Allows for continuity of care	Always ○ ○ Never ○ Supporting evidence:	
Inpatients are provided with a discharge plan and discharge report in advance, prior to discharge → Provides the person and their valued others an opportunity to discuss any areas of the plan they do not understand and to seek required support in advance	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Check that the person knows their designated contact for the service, their contact details and the next steps in their care plan
- Ensure regular follow-up with the person

Standard S7: A child with a congenital limb loss or limb amputation requires specialist care and including access to a specialist paediatric limb loss service

Element and rationale	Self-rating and your evidence	Action plan and timeframe
There is a documented process for accessing and referring to local genetic and specialist paediatric limb loss services → Facilitates optimal outcomes for the person; in particular, geneticists provide advice on diagnosis, counselling and management	Fully documented ○ ○ Not documented ○ Supporting evidence:	
Contact is made with the local adult clinic when treating adolescents (13–18 years) → Facilitates transition of care	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Review and update details of specialist paediatric limb loss service(s), as required
- Locate local areas to suggest to parents/carers where the child can participate in sport and/or physical activity
- Consider having resources that are paediatric-specific, e.g., educational material and referral pathways

Standard S8: The person who has experienced an upper limb amputation requires access to a specialist upper limb amputee rehabilitation service

Element and rationale	Self-rating and your evidence	Action plan and timeframe
There is a documented process for accessing specialist upper limb amputee clinics → Specialist upper limb amputee clinics may help the person return to their activities of daily living	Fully documented ○ ○ Not documented ○ Supporting evidence:	
Limb amputee rehabilitation referral is early and timely within the care journey → Rehabilitation services effectively work with amputees to optimise return to independent living	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Review and update details of specialist upper limb amputee clinic(s) and rehabilitation services, as required
- Ask and assess the person at review whether the amputation is significantly affecting them in everyday life

Standard P1: Care of the residual limb and management of risk factors for further amputation are addressed

Element and rationale	Self-rating and your evidence	Action plan and timeframe
There are documented processes for providing education on: • Contracture prevention • Wound breakdown • Skin issues • Infection control • Further amputations → Managing and reducing issues in the residual limb is vital to ongoing health, vitality and activities of daily living	Fully documented ○ ○ Not documented ○ Supporting evidence:	
Prior to surgery, there is a discussion with the person about expected outcomes → Prepares the person for surgery and allows the person to clarify any areas that remain unclear	Always ○ ○ Never ○ Supporting evidence:	
Rigid removable dressings are used in transtibial amputations, where there are no contraindications → Rigid removable dressings help protect the limb in the event of a fall	Always ○ ○ Never ○ Supporting evidence:	
Contact details (therapy, clinic and prosthetic) are given to the person along with their ongoing care plan → Immediate contact can be made should any residual limb issues occur	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Communicate any detected risks to the wider multispecialty team to ensure continuity of care
- A guide to rigid removable dressings can be found in Appendix 2

Standard P2: Education occurs across all stages of care

Element and rationale	Self-rating and your evidence	Action plan and timeframe
There is a documented process for the provision of educational resources → Education supports self-management for the person and their valued others	Fully documented ○ ○ Not documented ○ Supporting evidence:	
The majority of educational resources are available in a variety of formats → Educational materials and resources are available that reflect the cultural and linguistic diversity of the local population	Yes ○ ○ No ○ Supporting evidence:	
The person and their valued others receive education on: • The surgical procedure • Components of post-surgery care • Rehabilitation outcomes • Psychological needs • Ongoing care requirements → Supports empowerment and enablement, and facilitates a shared decision model	Always ○ ○ Never ○ Supporting evidence:	

Tips for implementation:

- Education is not the responsibility of any single member or discipline, but should be delivered throughout all stages of care by the care team
- Reiterate education along the care journey to help reinforce and meet the person's needs

Standard P3: Pain is assessed, managed and monitored across all stages of care

Element and rationale		Self-rating and your evidence	Action plan and timeframe
Pain assessment, education and management is documented for each person following an amputation	→ Comfort of the person is considered throughout the journey	Always ○ ○ ○ Never Supporting evidence:	
A pain management plan exists for each individual	→ Individual circumstances have been considered, e.g., contraindications to pharmacological interventions	Always ○ ○ ○ Never Supporting evidence:	
Pain management is monitored and addressed from an interdisciplinary perspective during all phases of care	→ All aspects of pain are considered	Always ○ ○ ○ Never Supporting evidence:	
Pain intervention (pharmacological and/or non-pharmacological) is offered	→ Pain is managed in the most effective way possible	Always ○ ○ ○ Never Supporting evidence:	

Tips for implementation:

- Suggested pain assessment tools can be found in the resource section of the standard (page 45)

Standard P4: Special consideration is given to the needs of specific populations

Element and rationale		Self-rating and your evidence	Action plan and timeframe
Specialist services are accessed when required For Aboriginal and Torres Strait Islander people/s: • Aboriginal liaison worker • Aboriginal chronic care team For people over 65 years of age: • aged care clinical nurse consultant For children transitioning to adult services: • transition care coordinators For physically active people: • exercise physiologist For culturally and linguistically diverse populations: • translation services, where required	→ There are certain risks associated with specific populations. By including specific specialist services with experience in different populations, any potential issues can be addressed earlier	Always ○ ○ ○ Never Supporting evidence:	

Tips for implementation:

- There may be other populations that require specific care that you see in everyday practice – list specialist services that you access and add them to an internal process document
- Locate specific patient support groups that could help with different populations

Published: June 2017
Review date: 2024