ACCRÉDITATION SANS FRONTIÈRES (ASF)
NON-GOVERNMENTAL, NON-PROFIT

ASF Health Standards Version 11

Standard 11: Rehabilitation

Core standard · applicability by facility type shown for each criterion

DOCUMENT NUMBER	ASF-HS11-S11
REVISION	01
DATE OF THIS REVISION	10 November 2026
STATUS	Approved for use
OWNER	Accréditation Sans Frontières (ASF)
APPROVED BY	Prof. Giorgi Pkhakadze, MD, MPH, PhD, Chair, Public Health Institute of Georgia
APPLIES TO SURVEYS STARTING AFTER	[date to be confirmed]
REVIEW	Every year, or earlier if the law, a cited guideline or the standard itself changes. Next scheduled review: 1 November 2027.
CONTROLLED COPY	The copy on france-asf.fr is the controlling copy. A printed copy is valid only for the revision shown on its cover.

REVISION HISTORY

Revision	Date	Change	Approved by
01	10 November 2026	First issue of the paper standard. Adapted from the web version of Standard 11 in ASF Health Standards Version 11.	Prof. Giorgi Pkhakadze

APPROVAL



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Date: 10 November 2026

Complete on its own, without internet access. References are listed in section 11. The current revision is at france-asf.fr.

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1 Introduction

This document is Standard 11 of ASF Health Standards. It sets out how a facility delivers rehabilitation safely and effectively: individualised plans built from a functional assessment, coordinated teams, goals agreed with patients and families, progress measured with validated tools, equipment matched to need, and planned discharge and aftercare.

A standard is a set of numbered criteria. Each criterion says what must be in place (the criterion statement), how it is rated for each setting, what the assessor will check and what evidence the facility must show. The guidance in this document explains what each criterion means in practice, so that a reader who has only this paper can understand and meet it.

Purpose of this document. Standard 11 makes sure that rehabilitation is planned around the patient, measured honestly, and continued at home and in the community after the patient leaves the facility.

Who should read it. Rehabilitation clinicians (physiotherapists, occupational therapists, speech and language therapists), nurses, the rehabilitation lead, the clinical governance lead, the chief executive, and the assessors who verify the facility. Each criterion names the positions responsible for it (section 8.2).

The standard is a tool to improve care, not a list of paperwork. Templates and forms named in this document are reference drafts. You may adapt them, replace them with your own, or upload your own documents, provided they meet the same criterion.

2 About ASF and this standard

Accréditation Sans Frontières (ASF) is a non-governmental, non-profit accreditation body. It was legally established in Paris in 2020. ASF develops health standards that are practical, affordable and open to all facilities, including those working with limited resources, in crisis, or in transition.

ASF believes accreditation should be accessible in every sense: geographically, so that facilities in remote areas can take part; financially, so that cost is not a barrier; and in language and format, so that staff can read and use the standard in their own working environment.

Each standard is an independent document. Standard 11 has been written so that it can be read and used on its own. It repeats the definitions, abbreviations and references it needs. A reader who has only this document can understand every criterion in it.

3 How to use this standard

If you deliver rehabilitation, read section 4 to confirm which criteria apply to your facility type, then section 5 to find the rating for your setting. Read each criterion from 11.1 to 11.9, paying attention to the rating, the guidance and the evidence. Prepare the evidence named in each criterion, covering the period stated.

If you are an assessor, use the sample and the checks in each criterion. The pass rule and the immediate-fail rule decide each criterion. A criterion is met only when all its checks are passed and no immediate-fail event is found.

Reading a criterion. Each criterion has: the criterion statement; the three ratings (humanitarian, transition and fragile, standard); the rating rule; the guidance; what good looks like; common mistakes; why it matters; the sample; the checks, with method, evidence and pass condition; the immediate-fail event; the documents with who writes, approves and checks them; the positions responsible; and the references.

Document codes. Each document has a code made of a topic prefix, a type and a number, for example ENV-SOP-001 (environment, procedure, 001). The type is one of FRM (form, a record kept as evidence), REG (register), PLN (plan),

POL (policy), SOP (standard operating procedure) or GDL (guide). The codes identify documents only. The full list is in section 12.

4 Scope

Standard 11 covers individualised rehabilitation plans, team coordination, goal-setting and education, progress measurement, equipment and assistive devices, discharge and reintegration planning, clinical assessment before treatment, aftercare plans, and advice for home. The applicability is shown in section 4.

The standard applies in three settings. The rating for each criterion is given for each setting, and the facility uses the rating for its own setting: **humanitarian settings** (emergency or crisis, very limited resources), **transition and fragile settings** (a health system in change or under strain), and **standard settings** (full resources).

WHERE STANDARD 11 APPLIES

Standard 11 applies when the facility offers rehabilitation services. For each facility type the table shows whether rehabilitation is a default service (expected) or an optional service (offered only if the facility provides it). The applicability of all 70 standards is in **Annex 1: Applicability of ASF Health Standards by facility type** (ASF-HS11-ANX01), published on france-asf.fr.

Criterion	Applies to
11.1 Individualised Rehabilitation Plan Based on Functional Assessment	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.
11.2 Multidisciplinary Team Coordination	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.
11.3 Patient and Family Goal-Setting and Education	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.
11.4 Progress Is Measured With Validated Functional Outcome Tools	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.
11.5 Equipment and Assistive Device Provision Matches Need	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.
11.6 Discharge and Community Reintegration Planning	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.
11.7 Each Patient Has a Clinical Assessment Before Treatment	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.
11.8 Every Discharged Patient Has an Aftercare Plan	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.

Criterion	Applies to
11.9 Patients Are Given Advice to Continue at Home	**default** in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic.

5 Ratings and colours

Rating	Colour	Meaning
Must		Required in every setting. Criteria that can directly affect a patient's life are always Must, and no setting lowers them.
Medium		Required, adapted to what a transition setting can realistically do.
Minimum		The lowest acceptable level in a humanitarian setting, where resources are very limited.

In standard settings every criterion is Must.

TRAINING LEVELS

Level	Colour	Meaning
Essential		Must be completed by the people named in the role table.
Recommended		Good practice. Not checked as a requirement.
Optional		May be used for development.

6 Abbreviations

Abbreviation	Meaning
ASF	Accréditation Sans Frontières (Accreditation Without Borders), a non-governmental, non-profit accreditation body
FRM	Form. A record that is filled in and kept as evidence
GDL	Guide. Reference guidance for staff
POL	Policy. A written statement of what the facility will do and why
REG	Register. A running record of entries, such as training, absence or working time
SOP	Standard operating procedure. A step-by-step description of how a task is done
ADL	Activities of daily living
ROM	Range of motion

DOCUMENT CODE PREFIXES

Prefix	Topic
REH	Rehabilitation

7 Terms and definitions

Term	Definition
Functional assessment	A structured check of what a patient can and cannot do in daily life, used to set rehabilitation goals.
Validated outcome tool	A measurement tool that has been tested for reliability, used to score function at set points.
Reintegration	Returning a patient to home, work, school or community life after treatment.
Aftercare plan	A written plan for the care a patient continues to receive after discharge.
Immediate fail	One event that means a criterion is not met, whatever else is in place.
Setting	The context in which a facility works: humanitarian, transition and fragile, or standard.

8 Standard 11 at a glance

Standard 11: Rehabilitation is a service standard of ASF Health Standards. It applies when the facility offers rehabilitation services, and covers how rehabilitation is planned, delivered, measured and continued after discharge.

The standard has nine criteria. Each is shown below and explained on its own page in section 9.

8.1 CRITERIA AND RATINGS

No.	Criterion	Humanitarian	Transition	Standard
11.1	Individualised Rehabilitation Plan Based on Functional Assessment	Minimum	Must	Must
11.2	Multidisciplinary Team Coordination	Minimum	Must	Must
11.3	Patient and Family Goal-Setting and Education	Minimum	Medium	Must
11.4	Progress Is Measured With Validated Functional Outcome Tools	Minimum	Medium	Must
11.5	Equipment and Assistive Device Provision Matches Need	Minimum	Medium	Must
11.6	Discharge and Community Reintegration Planning	Minimum	Medium	Must
11.7	Each Patient Has a Clinical Assessment Before Treatment	Minimum	Must	Must
11.8	Every Discharged Patient Has an Aftercare Plan	Minimum	Must	Must
11.9	Patients Are Given Advice to Continue at Home	Minimum	Medium	Must

8.2 RESPONSIBILITIES

Each criterion names the positions responsible for it. The facility sets its own reporting lines, and each position should have written terms of reference. ISCO-08 codes are shown for each role and are recorded in the staff register.

No.	Criterion	Positions responsible or involved
11.1	Individualised Rehabilitation Plan Based on Functional Assessment	Manager (ISCO 1342) · Nurse (ISCO 2221)
11.2	Multidisciplinary Team Coordination	Manager (ISCO 1342) · Secretary (ISCO 3344)
11.3	Patient and Family Goal-Setting and Education	Manager (ISCO 1342) · Nurse (ISCO 2221)
11.4	Progress Is Measured With Validated Functional Outcome Tools	Manager (ISCO 1342)
11.5	Equipment and Assistive Device Provision Matches Need	Manager (ISCO 1342) · Nurse (ISCO 2221)
11.6	Discharge and Community Reintegration Planning	Manager (ISCO 1342) · Nurse (ISCO 2221)

No.	Criterion	Positions responsible or involved
11.7	Each Patient Has a Clinical Assessment Before Treatment	Manager (ISCO 1342)
11.8	Every Discharged Patient Has an Aftercare Plan	Manager (ISCO 1342) · Nurse (ISCO 2221)
11.9	Patients Are Given Advice to Continue at Home	Manager (ISCO 1342)

8.3 TRAINING FOR STANDARD 11

Training is shown by course. Essential training must be completed by the people named. Recommended training is good practice. The colours follow section 5.

Course	Essential for	Recommended for	Criteria	Status
Aftercare & Follow-up: Standards for Safe Discharge (H-06)	Manager, Nurse	None	11.6, 11.8	In development
Clinical Assessment Before Physiotherapy Treatment (RHB-01)	Manager, Nurse	None	11.7	In development

Evidence of training may be a verified micro-credential in the GMJ Academy micro-credential portfolio, or a training certificate kept in the staff file.

11.1 Individualised Rehabilitation Plan Based on Functional Assessment

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Every patient receiving rehabilitation services has an individualised plan built from a documented functional assessment, not a generic protocol applied regardless of the patient's specific impairment and baseline function.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: every patient receiving rehabilitation has an individualised plan built from a documented functional assessment.

GUIDANCE

Every patient receiving rehabilitation services has an individualised plan built from a documented functional assessment, not a generic protocol applied regardless of the patient's specific impairment and baseline function.

A rehabilitation plan copied from another patient does not fit the person in front of you. A plan built from a functional assessment, specific to this patient's goals and abilities, is what makes rehabilitation work.

WHAT GOOD LOOKS LIKE

- The plan is written with the patient, in terms of their own goals, and is visible to every team member who works with them.

COMMON MISTAKES

- . A patient given a standard exercise protocol with no functional assessment on file.
- the facility has a functional assessment form and a plan template, but plans are not reviewed when function changes.

> **Why it matters.** A rehabilitation plan copied from another patient does not fit the person in front of you. A plan built from a functional assessment, specific to this patient's goals and abilities, is what makes rehabilitation work.

WHAT THE ASSESSOR CHECKS

Sample. Review the rehabilitation plans for 20 patients, with the functional assessment each plan is built on.

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1 Each patient has a functional assessment recorded before the plan is written.

Method. Check each plan for a functional assessment dated before the plan.

Evidence to show. Individualised rehabilitation plan based on functional assessment (REH-POL-001).

Pass when. Every sampled plan is preceded by a functional assessment.

2 **The plan is specific to the impairment found in the assessment.**

Method. Check each plan for goals and interventions that link to the assessed impairment.

Evidence to show. Rehabilitation plan record (REH-FRM-001).

Pass when. Every plan links its interventions to the assessed impairment.

3 **The plan is reviewed when the patient's function changes.**

Method. Compare each plan's review dates with the dates of functional reassessment.

Evidence to show. Rehabilitation plan record (REH-FRM-001).

Pass when. Every plan is reviewed within the interval set in REH-POL-001 and after any change in function.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A patient given a standard exercise protocol with no functional assessment on file. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-FRM-001	Rehabilitation plan record	Manager	Chief executive	Manager
REH-POL-001	Individualised rehabilitation plan based on functional assessment	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Individualised rehabilitation plan	— Must
Nurse (ISCO 2221)	Completes the The rehabilitation plan record	— Must

REFERENCES FOR THIS CRITERION

- WHO (2025). Using the Package of Interventions for Rehabilitation in Georgia. Used for: Use of the WHO Package of Interventions for Rehabilitation in Georgia: team-based rehabilitation, functional assessment and outcomes. Georgia-specific implementation. https://news.gmj.ge/guideline/using-the-package-of-interventions-for-rehabilitation-in-georgia/
- WHO (2024). Long-term care for older people: package for universal health coverage. Used for: Long-term care package for older people: functional assessment, team-based care, assistive devices, home-based support and exercise. Covers older people generally. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/

11.2 Multidisciplinary Team Coordination

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Rehabilitation care is coordinated across the relevant disciplines — physical therapy, occupational therapy, speech-language therapy, rehabilitation medicine, nursing, as applicable to the patient — through a shared process, not separate disciplines working in isolation from each other.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: rehabilitation is delivered by a coordinated multidisciplinary team with one named lead.

GUIDANCE

Rehabilitation care is coordinated across the relevant disciplines — physical therapy, occupational therapy, speech-language therapy, rehabilitation medicine, nursing, as applicable to the patient — through a shared process, not separate disciplines working in isolation from each other.

A rehabilitation patient often sees a physiotherapist, an occupational therapist, a doctor and a nurse. If they give conflicting advice, the patient is confused and recovery slows.

WHAT GOOD LOOKS LIKE

- A named lead coordinates the team, and the team meets on a set schedule with the plan on the table.

COMMON MISTAKES

- . Two disciplines giving opposite exercise instructions with no lead clinician and no review.
- the team works in parallel, but no single person owns the plan and the shared record is incomplete.

> **Why it matters.** A rehabilitation patient often sees a physiotherapist, an occupational therapist, a doctor and a nurse. If they give conflicting advice, the patient is confused and recovery slows.

WHAT THE ASSESSOR CHECKS

Sample. Review the team coordination records for 15 patients who received care from two or more rehabilitation disciplines.

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1 The disciplines involved in each patient's care are recorded in the plan.

Method. Check each multidisciplinary plan for the disciplines named.

Evidence to show. Multidisciplinary rehabilitation team coordination (REH-SOP-001).

Pass when. Every plan names the disciplines involved.

2 **The team reviews each patient at the set interval and records the review.**

Method. Check the team review register for each sampled patient against the interval.

Evidence to show. Team review register (REH-REG-001).

Pass when. Every sampled patient has team reviews at the set interval.

3 **Conflicting instructions are resolved and the lead clinician is named.**

Method. Check each review for any conflict noted and the resolution and lead named.

Evidence to show. Team review register (REH-REG-001).

Pass when. Every recorded conflict has a resolution and a named lead.

Pass. The criterion is met when every check above is passed.

Immediate fail. . Two disciplines giving opposite exercise instructions with no lead clinician and no review. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-SOP-001	Multidisciplinary rehabilitation team coordination	Manager	Chief executive	Chief executive
REH-REG-001	Team review register	Secretary	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Multidisciplinary rehabilitation team coordination	— Must
Secretary (ISCO 3344)	Keeps the Team review register	— Must

REFERENCES FOR THIS CRITERION

- WHO (2025). Using the Package of Interventions for Rehabilitation in Georgia. Used for: Use of the WHO Package of Interventions for Rehabilitation in Georgia: team-based rehabilitation, functional assessment and outcomes. Georgia-specific implementation. https://news.gmj.ge/guideline/using-the-package-of-interventions-for-rehabilitation-in-georgia/
- WHO (2024). Long-term care for older people: package for universal health coverage. Used for: Long-term care package for older people: functional assessment, team-based care, assistive devices, home-based support and exercise. Covers older people generally. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/

11.3 Patient and Family Goal-Setting and Education

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Rehabilitation goals are set collaboratively with the patient and, where appropriate, family, in understandable terms, with the patient and family informed of realistic expectations — not goals set unilaterally by the clinical team.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: patient and family goals are agreed and education is given and recorded.

GUIDANCE

Rehabilitation goals are set collaboratively with the patient and, where appropriate, family, in understandable terms, with the patient and family informed of realistic expectations — not goals set unilaterally by the clinical team.

A patient who helps set their own rehabilitation goals is more likely to work towards them. Their family, where appropriate, can help them reach those goals at home.

WHAT GOOD LOOKS LIKE

- Goals are agreed with the patient and family in plain language, and the education given is recorded with the patient's understanding checked.

COMMON MISTAKES

- . Goals set by staff with no patient involvement and no explanation of expected recovery.
- goals are written down, but the family is not consistently involved or the education is not recorded.

> **Why it matters.** A patient who helps set their own rehabilitation goals is more likely to work towards them. Their family, where appropriate, can help them reach those goals at home.

WHAT THE ASSESSOR CHECKS

Sample. Review the goal and expectation records for 15 patients, including whether family were involved where appropriate.

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1 **Goals are recorded with the patient, and with family where the patient agrees.**

Method. Check each goal record for the patient's signature or recorded agreement.

Evidence to show. Patient and family goal-setting and expectations (REH-SOP-002).

Pass when. Every goal record shows the patient's agreement.

2 **Realistic expectations are explained and recorded.**

Method. Check each record for the expectation statement and the understanding check.

Evidence to show. Rehabilitation goals and expectations record (REH-FRM-002).

Pass when. Every record states realistic expectations and the check made.

3 **Goals are written in understandable terms.**

Method. Read a sample of goals for plain-language wording.

Evidence to show. Rehabilitation goals and expectations record (REH-FRM-002).

Pass when. Every sampled goal can be understood by the patient.

Pass. The criterion is met when every check above is passed.

Immediate fail. . Goals set by staff with no patient involvement and no explanation of expected recovery. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-SOP-002	Patient and family goal-setting and expectations	Manager	Chief executive	Chief executive
REH-FRM-002	Rehabilitation goals and expectations record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Patient and family goal-setting and expectations	— Medium
Nurse (ISCO 2221)	Completes the The rehabilitation goals and expectations record	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2026). Nurturing care for children with developmental delays and disabilities: thematic brief. Used for: Family-centred care and education for children with developmental delays or disabilities. Child-specific. https://news.gmj.ge/guideline/nurturing-care-for-children-with-developmental-delays-and-disabilities-thematic-brief/
- WHO (2023). Guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings. Used for: Non-surgical management of chronic back pain, including exercise, education and self-management. Pain-specific. https://news.gmj.ge/guideline/guideline-for-non-surgical-management-of-chronic-primary-low-back-pain-in-adults-in-primary-and-community-care-settings/

11.4 Progress Is Measured With Validated Functional Outcome Tools

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Rehabilitation progress is tracked using a validated functional outcome measurement tool appropriate to the patient's condition, applied consistently at defined intervals, not relying on informal clinical impression alone.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: progress is measured with a validated functional outcome tool at set points, and the results change the programme.

GUIDANCE

Rehabilitation progress is tracked using a validated functional outcome measurement tool appropriate to the patient's condition, applied consistently at defined intervals, not relying on informal clinical impression alone.

Saying a patient is improving is not the same as measuring it. A validated functional tool gives a number that can be compared over time and shows whether the treatment is working.

WHAT GOOD LOOKS LIKE

- Scores are shared with the patient, so that they can see their own progress and take part in setting the next goal.

COMMON MISTAKES

- . Progress recorded only as "improving" over six months with no tool or score.
- the tool is used at admission only and not repeated at set intervals.

> **Why it matters.** Saying a patient is improving is not the same as measuring it. A validated functional tool gives a number that can be compared over time and shows whether the treatment is working.

WHAT THE ASSESSOR CHECKS

Sample. Review the progress records for 15 patients on rehabilitation programmes lasting more than 4 weeks.

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1 **Progress is measured with a named validated tool at baseline, at set intervals and at discharge.**

Method. Check the progress record for each sampled patient for the tool named and a score at each point.

Evidence to show. Functional assessment and programme record (REH-FRM-006).

Pass when. Every sampled patient has a baseline score and at least one repeat score recorded with the named tool.

2 **The tool suits the patient's condition and is applied the same way across the programme.**

Method. Check that the tool named matches the patient's condition and that the same tool is used across the programme.

Evidence to show. Functional assessment and programme record (REH-FRM-006).

Pass when. Each sampled patient is measured with a tool appropriate to their condition, and the tool does not change without a recorded reason.

3 **Scores are reviewed by the team and used to change the programme.**

Method. Check the record of each review meeting for the score discussed and any change made.

Evidence to show. Functional assessment and programme record (REH-FRM-006).

Pass when. At least one documented change to the programme follows a review that showed little or no progress.

Pass. The criterion is met when every check above is passed.

Immediate fail. . Progress recorded only as "improving" over six months with no tool or score. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-FRM-006	Functional assessment and programme record	Manager	Chief executive	Manager
REH-POL-001	Individualised rehabilitation plan based on functional assessment	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2025). Using the Package of Interventions for Rehabilitation in Georgia. Used for: Use of the WHO Package of Interventions for Rehabilitation in Georgia: team-based rehabilitation, functional assessment and outcomes. Georgia-specific implementation. https://news.gmj.ge/guideline/using-the-package-of-interventions-for-rehabilitation-in-georgia/

11.5 Equipment and Assistive Device Provision Matches Need

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Assistive devices and equipment — mobility aids, orthotics, adaptive equipment — are assessed, fitted, and provided to match the patient's actual functional need, with patient and caregiver trained in correct use before discharge.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: equipment and assistive devices are matched to need, fitted by a trained person and checked for safety.

GUIDANCE

Assistive devices and equipment — mobility aids, orthotics, adaptive equipment — are assessed, fitted, and provided to match the patient's actual functional need, with patient and caregiver trained in correct use before discharge.

A patient given a wheelchair that is too big, or a brace that does not fit, can fall or develop sores. Devices should match the need and be checked for fit and condition.

WHAT GOOD LOOKS LIKE

- Equipment is matched to the functional assessment, fitted by a trained person, and the fit is checked at each follow-up.

COMMON MISTAKES

- . A wheelchair issued without fitting, with no caregiver training.
- equipment is issued on request without a fitting or a follow-up check.

> **Why it matters.** A patient given a wheelchair that is too big, or a brace that does not fit, can fall or develop sores. Devices should match the need and be checked for fit and condition.

WHAT THE ASSESSOR CHECKS

Sample. Review the equipment and assistive device records for 15 patients issued a device.

1 Each device is assessed for the patient's functional need before it is issued.

Method. Check each record for the assessment dated before issue.

Evidence to show. Assistive device assessment, provision and training (REH-SOP-003).

Pass when. Every issued device has a need assessment before issue.

2 **The device is fitted and the fit is recorded.**

Method. Check each record for the fitting entry and the fit result.

Evidence to show. Assistive device fitting and training record (REH-FRM-003).

Pass when. Every device has a fitting record.

3 **Equipment is checked for safety and maintained at set intervals.**

Method. Check the maintenance log for each item of equipment in use.

Evidence to show. Assistive device fitting and training record (REH-FRM-003).

Pass when. Each item in use has a safety check recorded within the interval set in the plan.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A wheelchair issued without fitting, with no caregiver training. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-SOP-003	Assistive device assessment, provision and training	Manager	Chief executive	Chief executive
REH-FRM-003	Assistive device fitting and training record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Assistive device assessment, provision and training	— Medium
Nurse (ISCO 2221)	Completes the The assistive device fitting and training record	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2024). Long-term care for older people: package for universal health coverage. Used for: Long-term care package for older people: functional assessment, team-based care, assistive devices, home-based support and exercise. Covers older people generally. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/
- WHO (2023). Primary Ear and Hearing Care: Training Manual. Used for: Hearing aid provision and referral in primary care. Assistive device provision for hearing loss only. https://news.gmj.ge/guideline/primary-ear-and-hearing-care-training-manual/

11.6 Discharge and Community Reintegration Planning

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Discharge planning for rehabilitation patients begins early in the course of treatment and addresses home environment, caregiver support, community resources, and follow-up therapy — not a last-minute checklist completed at the point of discharge.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: discharge and community reintegration are planned before the patient leaves.

GUIDANCE

Discharge planning for rehabilitation patients begins early in the course of treatment and addresses home environment, caregiver support, community resources, and follow-up therapy — not a last-minute checklist completed at the point of discharge.

Patients who leave rehabilitation without a plan for home and community often fall back. Planning the discharge from the start, with the community and the family, makes the gains last.

WHAT GOOD LOOKS LIKE

- Discharge planning starts at admission, and the community services the patient will need are named before discharge.

COMMON MISTAKES

- . A patient with no home access arrangements discharged on the day of referral.
- a discharge letter is written, but community services are not contacted before the patient leaves.

> **Why it matters.** Patients who leave rehabilitation without a plan for home and community often fall back. Planning the discharge from the start, with the community and the family, makes the gains last.

WHAT THE ASSESSOR CHECKS

Sample. Review the discharge and reintegration plans for 15 rehabilitation patients discharged in the last 6 months.

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1 Discharge planning starts early and is dated from admission.

Method. Check each plan for the start date against the admission date.

Evidence to show. Discharge and community reintegration planning (REH-SOP-004).

Pass when. Every plan starts within the defined period from admission.

2 **The plan addresses home environment, caregiver support, community resources and follow-up therapy.**

Method. Check each plan for the four elements.

Evidence to show. Discharge and reintegration plan record (REH-FRM-004).

Pass when. Every plan addresses all four elements.

3 **The plan is agreed with the patient and caregiver before discharge.**

Method. Check each plan for the patient and caregiver agreement.

Evidence to show. Discharge and reintegration plan record (REH-FRM-004).

Pass when. Every plan is agreed before discharge.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A patient with no home access arrangements discharged on the day of referral. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-SOP-004	Discharge and community reintegration planning	Manager	Chief executive	Chief executive
REH-FRM-004	Discharge and reintegration plan record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Discharge and community reintegration planning	— Medium
Nurse (ISCO 2221)	Completes the The discharge and reintegration plan record	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2024). Long-term care for older people: package for universal health coverage. Used for: Long-term care package for older people: functional assessment, team-based care, assistive devices, home-based support and exercise. Covers older people generally. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/
- WHO (2025). Using the Package of Interventions for Rehabilitation in Georgia. Used for: Use of the WHO Package of Interventions for Rehabilitation in Georgia: team-based rehabilitation, functional assessment and outcomes. Georgia-specific implementation. https://news.gmj.ge/guideline/using-the-package-of-interventions-for-rehabilitation-in-georgia/

11.7 Each Patient Has a Clinical Assessment Before Treatment

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	Must	Must

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A physiotherapist assesses each patient before treatment begins. The assessment records the problem, the goals, any contraindications, and any red flags that need urgent medical review. Red flags are referred to a doctor, and the treatment goals are agreed with the patient and recorded.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: every patient has a clinical assessment before treatment starts, with risks recorded and acted on.

GUIDANCE

A physiotherapist assesses each patient before treatment begins. The assessment records the problem, the goals, any contraindications, and any red flags that need urgent medical review. Red flags are referred to a doctor, and the treatment goals are agreed with the patient and recorded.

Physiotherapy starts with a clear picture of the patient's problem, function and goals. Without an assessment before treatment, the treatment is guesswork and cannot be measured later.

WHAT GOOD LOOKS LIKE

- The assessment is done by a clinician competent to judge safe exercise, and the patient is told what it found.

COMMON MISTAKES

- . A patient with a new neurological deficit treated without urgent medical referral.
- an assessment is done, but risks are not recorded or acted on before treatment.

> **Why it matters.** Physiotherapy starts with a clear picture of the patient's problem, function and goals. Without an assessment before treatment, the treatment is guesswork and cannot be measured later.

WHAT THE ASSESSOR CHECKS

Sample. Review the assessment records for 20 patients at the start of physiotherapy treatment.

1 A clinical assessment is completed before the first treatment session.

Method. Check the first treatment entry for each sampled patient against the assessment date.

Evidence to show. Rehabilitation plan record (REH-FRM-001).

Pass when. Every sampled patient has a clinical assessment dated before the first treatment.

2 **The assessment covers medical history, medicines and risks to safe exercise.**

Method. Check each assessment against the areas listed in the assessment form.

Evidence to show. Rehabilitation plan record (REH-FRM-001).

Pass when. All listed areas are completed for every sampled patient.

3 **Where a risk is found, treatment is adjusted or referred before it starts.**

Method. Check each assessment that records a risk for a documented adjustment or referral.

Evidence to show. Rehabilitation plan record (REH-FRM-001).

Pass when. Each recorded risk has a documented response before treatment starts.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A patient with a new neurological deficit treated without urgent medical referral. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-FRM-001	Rehabilitation plan record	Manager	Chief executive	Manager
REH-FRM-006	Functional assessment and programme record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

11.8 Every Discharged Patient Has an Aftercare Plan

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Each discharged patient receives a written aftercare plan, explained and checked for understanding, and sent to the next provider.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: every discharged patient has a written aftercare plan that reaches the next provider.

GUIDANCE

Each discharged patient receives a written aftercare plan, explained and checked for understanding, and sent to the next provider.

Patients who leave without a written plan often return or harm themselves. A written, explained plan sent to the next provider keeps the care going.

WHAT GOOD LOOKS LIKE

- The aftercare plan is given to the patient in writing and sent to the next provider the same day.

COMMON MISTAKES

- . A patient discharged with no written aftercare plan.
- an aftercare plan exists, but it is not given to the patient or sent to the community provider.

> **Why it matters.** Patients who leave without a written plan often return or harm themselves. A written, explained plan sent to the next provider keeps the care going.

WHAT THE ASSESSOR CHECKS

Sample. Review the discharge records for 20 patients discharged from rehabilitation in the last 3 months.

1 A written aftercare plan is given to every discharged patient.

Method. Check each discharge record for the aftercare plan issued.

Evidence to show. Written aftercare plan at discharge (REH-SOP-005).

Pass when. Every discharged patient has a written plan.

2 The plan is explained and understanding is checked.

Method. Check each plan for the explanation and the understanding check recorded.

Evidence to show. The aftercare plan form (REH-FRM-005).

Pass when. Every plan records the explanation and the check.

3 The plan is sent to the next provider.

Method. Check each plan for the transfer to the next provider and the date sent.

Evidence to show. The aftercare plan form (REH-FRM-005).

Pass when. Every plan is sent to the next provider.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A patient discharged with no written aftercare plan. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-SOP-005	Written aftercare plan at discharge	Manager	Chief executive	Chief executive
REH-FRM-005	The aftercare plan form	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Written aftercare plan at discharge	— Must
Nurse (ISCO 2221)	Completes the The aftercare plan form	— Must

REFERENCES FOR THIS CRITERION

- WHO (2025). Guidelines on meningitis diagnosis, treatment and care. Used for: Covers follow-up and long-term sequelae after bacterial meningitis, including rehabilitation. Meningitis-specific. https://news.gmj.ge/guideline/guidelines-on-meningitis-diagnosis-treatment-and-care/
- WHO (2024). Long-term care for older people: package for universal health coverage. Used for: Long-term care package for older people: functional assessment, team-based care, assistive devices, home-based support and exercise. Covers older people generally. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/
- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

11.9 Patients Are Given Advice to Continue at Home

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: default in Long-term care; **optional** in Hospital, Ambulatory clinic, Primary health clinic, Telemedicine, Home care, Fitness and wellness. **Not applicable to:** Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Patients receive written advice and exercises to continue at home, explained to them. Understanding is checked by teach-back as set out in the patient understanding rule.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: patients and carers are given advice to continue rehabilitation at home, and check they understand it.

GUIDANCE

Patients receive written advice and exercises to continue at home, explained to them. Understanding is checked by teach-back as set out in the patient understanding rule.

Most of a patient's progress happens between visits. Written advice and exercises that the patient understands and can follow at home make the treatment last beyond the clinic.

WHAT GOOD LOOKS LIKE

- Advice is checked with the patient by asking them to explain it back in their own words.

COMMON MISTAKES

- . A patient sent home with exercises not written down or explained.
- advice is given verbally only and is not recorded.

> **Why it matters.** Most of a patient's progress happens between visits. Written advice and exercises that the patient understands and can follow at home make the treatment last beyond the clinic.

WHAT THE ASSESSOR CHECKS

Sample. Review the home advice records for 15 patients discharged with a home exercise programme.

1 The advice is explained to the patient.

Method. Check each record for the explanation entry.

Evidence to show. Written aftercare plan at discharge (REH-SOP-005).

Pass when. Every sampled record shows the explanation.

2 Advice is given in a language and format the patient and carer understand.

Method. Check the discharge advice for language and format, and for an interpreter record where one is needed.

Evidence to show. Rehabilitation plan record (REH-FRM-001).

Pass when. Advice is given in the language the patient understands, and a copy is kept in the record.

3 **Advice covers exercise, equipment use and when to seek help.**

Method. Check each advice sheet against these three topics.

Evidence to show. Rehabilitation plan record (REH-FRM-001).

Pass when. All three topics are covered for every sampled patient.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A patient sent home with exercises not written down or explained. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
REH-SOP-005	Written aftercare plan at discharge	Manager	Chief executive	Chief executive

Other records in the criterion: REH-FRM-001 Rehabilitation plan record

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Written aftercare plan at discharge	— Medium
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2023). Guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings. Used for: Non-surgical management of chronic back pain, including exercise, education and self-management. Pain-specific. https://news.gmj.ge/guideline/guideline-for-non-surgical-management-of-chronic-primary-low-back-pain-in-adults-in-primary-and-community-care-settings/
- WHO (2024). Long-term care for older people: package for universal health coverage. Used for: Long-term care package for older people: functional assessment, team-based care, assistive devices, home-based support and exercise. Covers older people generally. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/

10 Questions and answers

Does Standard 11 apply to every facility?
No. It applies when the facility offers rehabilitation services. Section 4 shows, for each facility type, whether rehabilitation is a default or an optional service, and where it does not apply.

Who leads the rehabilitation team?
Criterion 11.2 requires one named lead for the team. The lead is written into the plan and recorded in the team register.

What if a validated tool is not available in our language?
Choose a validated tool that is available, record the reason for the choice, and apply it the same way throughout the programme.

Do I have to use the forms on this page?
No. They are reference drafts. Adapt them, write your own, or upload your own, provided the same criterion is met and the evidence can be shown.

The criterion text is the authority. These answers summarise it.

11 References

CITED FOR CRITERIA

1. WHO (2025). Using the Package of Interventions for Rehabilitation in Georgia. Used for: Use of the WHO Package of Interventions for Rehabilitation in Georgia: team-based rehabilitation, functional assessment and outcomes. Georgia-specific implementation. https://news.gmj.ge/guideline/using-the-package-of-interventions-for-rehabilitation-in-georgia/ (criterion 11.1, 11.2, 11.4, 11.6)
2. WHO (2024). Long-term care for older people: package for universal health coverage. Used for: Long-term care package for older people: functional assessment, team-based care, assistive devices, home-based support and exercise. Covers older people generally. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/ (criterion 11.1, 11.2, 11.5, 11.6, 11.8, 11.9)
3. WHO (2026). Nurturing care for children with developmental delays and disabilities: thematic brief. Used for: Family-centred care and education for children with developmental delays or disabilities. Child-specific. https://news.gmj.ge/guideline/nurturing-care-for-children-with-developmental-delays-and-disabilities-thematic-brief/ (criterion 11.3)
4. WHO (2023). Guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings. Used for: Non-surgical management of chronic back pain, including exercise, education and self-management. Pain-specific. https://news.gmj.ge/guideline/guideline-for-non-surgical-management-of-chronic-primary-low-back-pain-in-adults-in-primary-and-community-care-settings/ (criterion 11.3, 11.9)
5. WHO (2023). Primary Ear and Hearing Care: Training Manual. Used for: Hearing aid provision and referral in primary care. Assistive device provision for hearing loss only. https://news.gmj.ge/guideline/primary-ear-and-hearing-care-training-manual/ (criterion 11.5)
6. WHO (2025). Guidelines on meningitis diagnosis, treatment and care. Used for: Covers follow-up and long-term sequelae after bacterial meningitis, including rehabilitation. Meningitis-specific. https://news.gmj.ge/guideline/guidelines-on-meningitis-diagnosis-treatment-and-care/ (criterion 11.8)
7. World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/ (criterion 11.8)

INTERNATIONAL STANDARDS CITED

1. International Labour Organization (2008). International Standard Classification of Occupations, ISCO-08. Geneva: ILO.

12 Document register

Every document code used in Standard 11, with its type and the criteria that use it. The codes identify the documents; a facility may use its own document if it meets the same criterion.

Code	Document	Type	Criteria
REH-FRM-001	Rehabilitation plan record	Form (record)	11.1, 11.7, 11.9
REH-FRM-002	Rehabilitation goals and expectations record	Form (record)	11.3
REH-FRM-003	Assistive device fitting and training record	Form (record)	11.5
REH-FRM-004	Discharge and reintegration plan record	Form (record)	11.6
REH-FRM-005	The aftercare plan form	Form (record)	11.8
REH-FRM-006	Functional assessment and programme record	Form (record)	11.4, 11.7
REH-POL-001	Individualised rehabilitation plan based on functional assessment	Policy	11.1, 11.4
REH-REG-001	Team review register	Register	11.2
REH-SOP-001	Multidisciplinary rehabilitation team coordination	Procedure (SOP)	11.2
REH-SOP-002	Patient and family goal-setting and expectations	Procedure (SOP)	11.3
REH-SOP-003	Assistive device assessment, provision and training	Procedure (SOP)	11.5
REH-SOP-004	Discharge and community reintegration planning	Procedure (SOP)	11.6
REH-SOP-005	Written aftercare plan at discharge	Procedure (SOP)	11.8, 11.9