The Rehabilitation Management System: Evaluating and planning physical rehabilitation services

Rehabilitation services Unit
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Ensuring quality and affordable rehabilitation services to anyone in need is at the heart of Handicap International mandate and strategy. The organisation is implementing physical rehabilitation projects in 40 countries, from community-based services to national referral centres, training specialised human resources and setting up logistical, management and referral mechanisms to policy support to health and/or social ministries. Based on this experience, Handicap International considers that rehabilitation services are a key element to achieve inclusive health; it is an essential component of the continuity of care and of Universal Health Coverage. It reflects a growing recognition at the global level of the essential role of rehabilitation services in ensuring health and participation for all, including settings where resources are limited.

The Rehabilitation Management System was initially developed to allow for more effective and reliable analysis of the quality of rehabilitation services in low resource countries. It draws on international standards, consensus and evidence and it is made of a set of scorecards that are used to monitor key components of management and support service planning. The initial instrument went through several participatory revisions and has been now implemented by Handicap International partners for about 6 years. While it covers domains that are specific to rehabilitation services, it is aligned to the broader health system strengthening framework. It is currently used in around 14 physical rehabilitation centers in 8 countries where settings and governance systems considerably vary, reflecting the different stages of development of physical rehabilitation services worldwide.

The “Rehabilitation Management System: Evaluating and planning Physical Rehabilitation services” guide follows the revision of the RMS scorecards, as a response to the demand from partner organisations, programmes and the Handicap International’s Rehabilitation Technical Unit for a greater adaptability of the system. It is hoped that this guide will further assist partners and programmes in implementing the RMS in effective and strategic management of their services in order to provide the highest quality care in the most sustainable manner.

The Rehabilitation Unit would like to give a special thanks to the partner organisations who have been implementing the RMS. They provided specific recommendations and suggestions for the revision, based on their daily practice and taking into account lessons learned. Special thanks go to USAID who funded the project STRIDE in Nepal and supported the first steps of the development of the guide.
1 Some elements of terminology

**Appropriate technology principles:** Provision of assistive technology that ensures proper fit and alignment based on sound biomechanical principles which suits the need of the individual.

**Chronic conditions:** Also known as Noncommunicable diseases (NCDs), chronic diseases, are not passed from person to person. They are of long duration and generally slow progression. The four main types of chronic diseases are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.

**Continuing Professional Development (CPD):** CPD helps health professionals to maintain, improve and broaden their knowledge, expertise and competence. CPD refers to the process of tracking and documenting the skills, knowledge and experience that you gain both formally and informally as you work, beyond any initial training.

**Environmental Standards:** An environmental standard is a policy guideline that regulates the effect of human activity upon the environment.

**Evidence Based Practice:** Integration of clinical expertise, external scientific evidence, and client/patient/caregiver perspectives to provide high-quality services reflecting the interests, values, needs, and choices of the individuals who benefit from a service.

**Gender equity:** Specific measures must be designed to eliminate inequalities between women and men, discrimination and to ensure equal opportunities.

**Human Resources (HR):** The company department charged with finding, screening, recruiting and training job applicants, as well as administering employee-benefit programs.

**Occupational Health and Safety (OH&S):** Occupational health and safety is concerned with protecting the safety, health and welfare of people engaged in work or employment.

**Outcome measures:** An outcome measure is the result of a test that is used to objectively determine the baseline function of a patient at the beginning of treatment. Once treatment has commenced, the same instrument can be used to determine progress and treatment efficacy.

**Personal Protective Equipment (PPE):** Specialized clothing or equipment worn by employees for protection against health and safety hazards.
2 Introduction to the Rehabilitation Management System

2.1 Quality Physical Rehabilitation is everyone’s right

Numerous international instruments reinforce the importance of accessible and affordable, high-quality physical rehabilitation services. The United Nations Convention on the Rights of Persons with Disabilities (CRPD), in particular, calls on State Parties to promote access to healthcare for persons with disabilities, as well as to promote personal mobility and independent living. This means quality physical rehabilitation services including physical therapy, occupational therapy and the provision of quality assistive technology are needed.

Management and quality assurance of physical rehabilitation: Using quality management approaches can help make rehabilitation services more effective and efficient. This can help ensure that high quality services are available consistently and sustainably.

2.2 Purpose of the RMS

The overall purpose of the Rehabilitation Management System (RMS) is to assist rehabilitation service providers in effective and strategic management of their services in order to provide the highest quality care in the most sustainable manner.

To achieve this, the RMS a) summarises the literature concerning good practice, legal requirements and agreed standards and guidelines, b) facilitates internal examination of compliance with those guidelines, and c) helps to systematise improvement of those areas.

2.3 RMS development process

As far as possible, this document makes recommendations on the basis of sound evidence, especially from review documents or consensus papers. It also takes into account guidelines or recommendations from relevant national and international documents. Users of the system are encouraged to read those documents. Knowing where the standards come from can help improve performance and knowledge of what is expected, and why. This can help improve areas where there are problems. The system has been tested in many countries and contexts. We have made many changes based on the feedback from users in these countries.
2.4 Scope of the RMS

This management system is not intended to be a step-by-step recipe for all activities in a physical rehabilitation service. Nor is it intended to be a detailed, comprehensive ‘toolkit’ with individual tools and instruments for all the steps necessary to provide high-quality physical rehabilitation care.

Instead, this Rehabilitation Management System (RMS) combines elements of a manual, a measurement system and a strategic planning process. This is so it can be adapted to many situations and contexts. It should help organise how other tools and systems are used. The RMS is intended to be relevant to most physical rehabilitation services. However, the standards are practical and relevant for most types of facility, you might need to think about the standards and consider how they are relevant to their particular working contexts.

Using these scorecards means that the final result is a set of numbers that:

- Are highly aggregated – that is, each indicator takes many different variables into one large indicator
- Do not tell us about the causes of limitations in final scores
- Indicate only ‘snapshots’ in time, and not how variables and indicators may fluctuate over time.

The purpose of using the RMS is to create a meaningful list of individual indicators that can be used to assess the quality of a rehabilitation service against core standards. But, reducing a complex set of processes into a small number of ‘scores’, is not enough.

For this reason, this management system:

- Describes the expected standards in detail
- Encourages long-term monitoring of important quality and service indicators that are not part of the management system
- Is intended to be modified according to the particular setting of the service

In this way, the system is a scaffold onto which many other measurements, processes and indicators, from projects, pre-existing management approaches and so on, can be attached.

Why no comprehensive protocols on specific processes within a rehabilitation service?

People who are responsible for managing clinical services or processes like procuring resources or making referrals, may be looking for specific, step-by-step protocols. They may also be seeking a comprehensive ‘toolkit’, including templates for all (or most) of the individual measurements, processes or actions involved in managing a rehabilitation service effectively.

However, even a simple analysis of most rehabilitation services reveals that:

- While most rehabilitation services contain common elements, there are very few that are exactly the same, even within one country
- Many rehabilitation services exist within an organisation that provides other services
• There are literally hundreds of processes in the average rehabilitation service.

For these reasons a total package of step-by-step instructions, complemented with appropriate ‘tools’ to monitor those steps, would be a very large and complex document. Importantly, it is very unlikely it would be used, because:

• It would be overwhelming to incorporate all of the processes into pre-existing systems in a reasonable period of time
• There are often insufficient human resources to enact the change required to incorporate all those tools
• Rehabilitation providers may already have analogous tools in place, and change may be redundant
• Some processes, especially concerning financial and related governance aspects, are highly variable according to the specific legal and other requirements of the local setting
• Many processes are driven by the experience and common practice of staff. In some situations, this is perfectly appropriate – superimposing additional bureaucracy would be unpopular and probably rejected
• Selecting which treatment protocols should be included would be very complex. Some have strong evidence, others have weak or very little evidence.

In other situations, particularly in specific diagnostic groups, there may be many advantages to introducing specific treatment protocols where they are not already in place. However, this is largely the responsibility of individual facilities. In that specific example, this management system encourages analysis of whether those systems exist, introduction and continuous improvement of those systems, rather than introducing the systems themselves.

Perhaps more importantly, there are already many examples of documents that help plan and evaluate rehabilitation services. For example, the ISPO Planning, Monitoring and Evaluation of P&O Programmes (2004) aids in establishing pre-conditions for setting up a new P&O program. The P&O Project and Programme Guides (2007) establish many important criteria for ongoing management of facilities.

However, those documents are principally oriented to prosthetics and orthotics facilities, and do not offer a step-by-step process to examine compliance with the proposed standards.

Many facilities simply do not use these documents, because examining the standards, measuring compliance and planning responses is extremely difficult. This is both because the standards are challenging to attain and because managing change and setting up priority areas for responses is complex, particularly where there are low human and financial resources.

The RMS seeks to build on that previous work with a system for measuring and analysing existing services and prioritising and planning responses for quality improvement.
2.5 **Suggested use of the RMS**

The *RMS* should be used systematically and routinely. While it is comprehensive, the system condenses many areas into a small number of core areas, each with a scorecard. The scorecards will orient you to strong and weak areas, and can be used to develop strategic planning for improvements that target those areas found to be weak.

The RMS may also be a useful summary of relevant policies, guidelines, consensus, experience, and research evidence. These can be used to plan, monitor, evaluate or manage projects.

The main purpose of this system is to allow centre managers and staff to assess their own performance, and make changes in a systematic way.

But, the RMS might also be used:

- To agree on targets in partnership with technical or donor agencies to target areas that are the most important to develop
- As a self-study instrument before an external evaluation
- As a framework for external evaluation, so that the external evaluators and the service can agree on what aspects should be evaluated
- To prioritise and agree on standards to target.

Any management system or quality assurance process needs to be done routinely, at pre-determined intervals. The system proposed here provides options for examining different elements of an overall service, so it would be possible, for example, to stagger the analysis over a given period of time.

Some elements required to achieve high quality scores require ongoing monitoring. Some data collection will need to happen daily.

Used properly, the management system should not increase the time dedicated to quality management. Instead, it should focus managers on key indicators and areas of service. This should result in greater efficiency and reliability, since indicators are consistent from period to period, and the examination of those indicators is streamlined with strategic process adjustments to improve them.

The RMS is not designed to replace any existing indicators or monitoring and evaluation processes that a facility has in place, it is simply to provide an overview of how the service is performing in relation to key standards that contribute to the delivery of a quality rehabilitation service.

**Planning for implementation of services**

Using the RMS right at the start of implementing new services may help to know all of the different elements to plan for implementation. It might be overwhelming, too. It is suggested to use LITE scoring at the start, but referring to the full scorecards during planning and startup.
# 1 Overview of the RMS

## 1.1 Structure of the RMS

The RMS assesses the performance of a rehabilitation service in 6 core areas: Service Users, Service Outputs, Staff, Equipment & Supplies, Finances, and Management Processes. Each of these 6 areas is given a “Scorecard” that is divided into subsections (see figure 1). Subsections contain standards against which services evaluate their current performance and score them accordingly.

![Figure 1 - Structure of the Rehabilitation Management System](image-url)

<table>
<thead>
<tr>
<th>1</th>
<th>Service users</th>
<th>1.1 User focused approach</th>
<th>1.2 Client experience</th>
<th>1.3 Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Service outputs</td>
<td>2.1 Evidence Based Practice</td>
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<td>3</td>
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<td>3.2 Performance…</td>
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<tr>
<td>4</td>
<td>Equipment &amp; Supplies</td>
<td>4.1 Technology</td>
<td>4.2 Processes</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Finances</td>
<td>5.1 General financial procedures</td>
<td>5.2 Cost calculation</td>
<td>5.3 Cost recovery</td>
</tr>
<tr>
<td>6</td>
<td>Management Processes</td>
<td>6.1 Occupational health &amp; safety</td>
<td>6.2 Inclusive policies &amp; practices</td>
<td>6.3 Governance</td>
</tr>
</tbody>
</table>
Completing the scorecards requires reflection on the individual documents, practice, processes and instruments that define, drive and measure the rehabilitation service. In doing so, the system moves beyond an evaluation system and becomes part of a wider process intended to measure, monitor and improve the quality of the overall service and in particular, the rehabilitation services it provides.

1.2 The Scorecards

Each scorecard is divided into sub-sections that contain one or more standard. Each sub-section has an overall description of the standards contained within it and the expected level of performance, known as a “Summary indicator”. These are used in the ‘LITE’ scoring. The complete scorecards are used in the ‘Full’ scoring. Below is a brief description of each of the scorecards.

1.2.1 Scorecard 1 – Service users

This scorecard contains standards relating to the aspects of rehabilitation services that directly impact on service users.

It is divided into 3 subsections:

User focused approach – Five standards that consider the waiting time for services, how comprehensive the services received are and whether follow-up is provided. This section also looks at the involvement of clients in their own treatment planning and the opportunity for them to provide feedback.

Client experience – Three standards relating to the experience clients have in terms of the attitudes and behaviour of staff.

Accessibility – Three standards that assess whether services are affordable and are physically accessible by all people, and their availability within the community.

1.2.2 Scorecard 2 – Service outputs

This scorecard considers aspects of the everyday running and delivery of quality rehabilitation services.

It is divided into 4 subsections:

Evidence based practice – A single standard to look at whether staff are aware of the need to practice according to up to date evidence and how well they are supported by the service to do this.

Client pathway – Four standards that evaluate the procedures and communication required in providing a smooth pathway for clients through the service from registration to discharge.
Service planning – Two standards relating to determining the need for the service and whether there is appropriate strategic planning in place.

Monitoring and evaluation – Three standards to look at the processes in place to monitor and evaluate clinical outcomes, service quality and throughput.

1.2.3 Scorecard 3 – Staff

This scorecard contains standards that relate to human resources processes and staff management, including aspects of staff performance, training and salary.

It is divided into 2 subsections:

Staff management – Six standards that look at recruitment and termination processes, internal regulations, working environment and compliance with professional standards.

Performance, recognition & salary – Five standards looking at how the service manages salary and incentives, evaluation of staff performance, staff development and mentoring.

1.2.4 Scorecard 4 – Equipment and supplies

Scorecard 4 looks at the provision, procurement and management of assistive technology and consumable supplies needed in providing a rehabilitation service.

It is divided into 2 subsections:

Technology – The two standards for technology consider the service’s application of appropriate technology principles and the range and choice of technology options available to clients.

Processes – A further two standards relate to the procurement and management of stocks of both assistive technology and other consumable supplies used in delivering the service.

1.2.5 Scorecard 5 – Finances

Scorecard 5 looks at aspects of running a quality service as they relate to the financial management.

It is divided into 3 subsections:

General financial procedures – Three standards that look at the procedures in place to ensure efficient and transparent financial management, including account keeping and cash management.

Cost calculation – Two standards that relate to recording and monitoring of expenditure as well as costing for services.

Cost recovery – Two standards that consider the funding mechanisms in place to ensure ongoing quality services, and the policies and procedures for user fees.
1.2.6 Scorecard 6 – Management Processes

Scorecard 6 contains standards that relate to processes that enable the service to run safely, equitably, transparently, in a way that reduces impact on the environment and is prepared in the case of disasters.

It is divided into 5 subsections:

**Occupational health & safety** – Six standards that focus on providing a clean, safe working environment that is appropriate to the needs of the service, and processes for hazard management.

**Inclusive policies & practices** – Two standards relating to policies and procedures to ensure equitable service provision for users of all ages and gender, without discrimination.

**Governance** – Two standards that evaluate how well roles and responsibilities within the organisation are defined and if Governance mechanisms are clear, equitable and transparent, and representative of all stakeholders.

**Environment** – One standard that consider the impact of the service on the environment and efforts to minimise this.

**Disaster preparedness** – One standard to evaluate whether contingency plans are in place in case of small scale and major scale disasters.

1.3 Optional Standards

While all facilities are encouraged to score all standards, some standards are optional. These are highlighted in red on the scorecards (see example in figure 2 above). All other standards are considered to be core standards and must be scored.

Figure 2 - Optional standards are highlighted in red
In some cases, adaptations could be required to fit to national regulations and frameworks when they exist.

Acceptable reasons for not scoring optional standards are:

- When the function assessed by a standard is completed by a separate department and you do not have access to the information needed to score that standard.
- The standard is not relevant to your particular context (e.g. due to the size of your facility, funding sources etc.).
- There is no capacity within the rehabilitation service to influence the performance on a standard.

Your purpose for completing the RMS will determine if you should do a full scoring of all standards or remove the optional standards and focus on the core standards only.
2 Administration and Scoring

This chapter outlines the steps for using the RMS. Recalling that one of the objectives of the system is to act as a checklist on processes and other management requirements, it will be normal if your processes do not always follow those exactly as outlined in the standards.

The RMS is scored using an excel spreadsheet (available on GRAASP and SkillWeb) with 3 main parts:

- A dashboard, to orient users to the RMS process (see figure 3)
- Summary indicators and ‘Summary planning’ worksheet – used in LITE scoring
- Detailed scorecards and ‘Planning detail ‘worksheet – used for Full scoring.

![Figure 3 - The dashboard](image)

2.1 Preparation for administering the RMS

Before scoring, whether using the whole scoring system or its sub-elements, it is important to be prepared. Scoring doesn’t have to be done quickly, or on one occasion. It can be broken down into the elements, so the responsible managers can focus on their main areas of work. Some sections might be done more often than others. This will depend on the priorities of your particular service, staffing requirements, and the perceived need for strategic change.
There are several steps to complete before you commence scoring:

- Read the RMS guide and scorecards to familiarise yourself with the content
- Decide whether you wish to complete full scoring or LITE scoring
- Decide who is responsible for scoring each of the scorecards
- Prepare relevant supporting documentation
- Organise a time and place to meet to complete the scoring process
- Consider when and how the subsequent strategic planning will take place following scoring. This step is the reason for doing the scoring and is more important than the scores themselves.

2.1.1 Purpose of scoring

It is important to first be clear about your main purpose in using the RMS.

This will help you to decide whether you wish to complete the LITE scoring for an overview of your service, or full scoring for a more thorough analysis of your service’s performance.

2.1.2 Who should do the scoring?

Scoring can be completed by anyone with a good overall knowledge of your service, and will vary depending on the size and context of the facility, and the purpose of scoring as outlined above.

While it is likely to be a role for managers, there may be benefits to delegating responsibilities for scoring particular scorecards or sub-sections to different people within the organisation that have greater knowledge of the given areas. This could include managers, rehabilitation staff, administrative staff, service user representatives, HR managers etc. Suggestions of who to involve in completing the scorecard are made at the top of each scorecard.

Completing scorecards together as a team made up of representatives from the various levels of the organisation (e.g. manager, clinical staff and admin staff), rather than dividing up scoring, may also be a useful process to increase awareness of policies and procedures across the organisation and increasing accountability of all staff for providing a quality service.

Where scoring is divided among different people or groups, it is important that there is one person allocated who is responsible for overseeing and co-
ordinating the RMS scoring process. In locally –managed services such as non-government organisations, this person is usually the manager or director of the center. In government services, it might be the rehabilitation service coordinator or a higher administrative manager.

2.1.3 Gathering information

To complete the scorecards service managers, directors, staff and stakeholders will need to compile and examine a range of supporting documentation. These will include:

- Local policies, affiliation documents, legal documents
- Process and procedure documents, describing practices within the setting
- Monitoring and evaluation documents
- Other specific instruments that are used to measure elements described in the scorecards.

2.1.4 Key references

The following key documents and references may be useful to review prior to scoring or to assist planning:

- Priority Assistive Products List (WHO, 2016) Available at: http://www.who.int/phi/implementation/assistive_technology/EMP_PHI_2016.01/en/
- Quality of care: a process for making strategic choices in health systems (WHO, 2006) Available at: www.who.int/management/quality/assurance/QualityCare_B.Def.pdf?ua=1
- WHO Health systems framework Available at: http://www.wpro.who.int/health_services/health_systems_framework/en/
2.2 LITE scoring

LITE scoring using the “Summary indicators” provides an overview of how your service is performing. It can be a good starting point by doing a quick scan of the key elements of your service before moving to scoring individual standards, and depending on the needs of your service and the time available this may be all that is required.

How to complete LITE scoring

In the figure 4 on the next page, you can see the ‘Summary 1.1’ for ‘User focused approach’. It says: “Service users are at the centre of everything we do. We ensure their experience is as good as it can be, through ensuring efficient, complete services in the right place at the right time. We seek to monitor and measure the client experience, act on those findings, and listen to our service users.”

This is the ‘expected standard’ for sub-section 1.1. In LITE scoring, the service team writes how their service is performing in the ‘remarks’ area. This analysis will then automatically populate to the ‘Planning Summary’ tab.

Now you start to see an overall, but simple, analysis starting to take shape.

There is space on the Planning summary worksheet to record plans for future service improvements (see figure 5).

The ‘Planning Summary’ worksheet can then be printed and used as an overall summary of the current situation and initial planning.
The overall summary of expected standards for part 1.1 is described. The user enters their response in the ‘remarks’ field.

Responses to the summary indicators are automatically populated here, and ideas about future plans can be written in the ‘plans for phase’ column.
2.3 FULL scoring

While the LITE scoring process can provide an overview of your service, full scoring is needed to understand how all the different parts of the service are operating, and where resources can be targeted to improve areas that are not up to standard.

How to complete full scoring

For each standard, a score between 0-3 is given depending on the service’s level of current performance. Indicators are provided as a guide for each score within a standard.

Using the ‘scoring tree’ shown in figure 6, we suggest first starting at score 2, which is the accepted standard. If it is correct and documented, it might be that your service exceeds the standard. If so, you decide whether your score is 2 or 3. If the statement is not right, your service requires some improvement. First, test score 1. If this is correct, score 1. If not, your score may be a zero, which means some action is required. This is OK, of course. The purpose of scoring is to target the priorities, so now that we recognise the issue, we can do something about it. If unable to decide between 2 scores, use the lower score.

If unsure, do not give a score but insert an ‘X’.

Once scores are entered in the scorecard, they automatically populate to the ‘Planning summary’ and ‘Planning detail’ worksheets to provide an overview of your service’s performance.

<table>
<thead>
<tr>
<th>Score</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Standard exceeded</td>
</tr>
<tr>
<td>2</td>
<td>Standard met</td>
</tr>
<tr>
<td>1</td>
<td>Some issues</td>
</tr>
<tr>
<td>0</td>
<td>Critical issues</td>
</tr>
</tbody>
</table>

Figure 6 - Scoring criteria
Starting with the standard, we test if it is achieved. If it is, we proceed to test whether it is exceeded. If it is met, but not exceeded, the score is 2, or if it is, 3. If the standard is not met, we first test whether 1 is correct, and if it is, a score is given. If it is not correct, the score is 0.
3 Analysing the results and formulating responses

3.1 Evaluating areas for improvement

Following scoring, managers should spend time examining in detail, the results and the causes of those scores. Scorecards with large areas of red (critical issues) or yellow (some issues) in particular should be examined closely.

Sometimes, low scores might be due to factors that are normally outside the control of the rehabilitation service and its management. Sometimes, it might be related to funding. Other times, there might be obvious responses, like implementing a system or activity that is not currently in place. In this way, the next step – creating goals – should become clear.

Sometimes, it will be hard to understand the precise causes of problems. How deeply users of this system want to go, is largely up to them. However, it is important to spend a lot of time on this. While that may sound burdensome, it should complement (or introduce) current strategic development processes. For some scoring elements, it will become clear that a change of process is not needed but documentation of the process is to improve transparency and consistency. How formal that task is will depend on how important and complex is. A system for discharge and referral, for instance, might be quite complex, because it involves clinical decisions and a detailed knowledge of the local health care system. A process describing how clients are registered in an accommodation facility, depending on the situation, may not need to be complicated at all, or this might be very complex.

Remember – it is up to the users to define what improvements can be made within your budget and in light of whatever legal or other requirements are at play, in any evaluation cycle.

On the basis of the scores and a review of the criteria in accordance with the local situation, areas for improvement should be identified and new targets, measurements and responses to achieve this should be developed.

Future developments of the RMS

We believe that the planning and strategic development aspect of the RMS is even more important than the scoring. In order to support teams to make use of the results of the RMS and develop strategic plans for service improvement, further trainings are going to be available. At this stage it is important to recall that the scoring system is based on commonly accepted standards. Low scores reflect violations of the basic standards that should be followed in any situation, regardless of the economic situation of that service. For instance, it is never ok to subject service users to unsafe environments. It is never okay to share personal health information without informed consent and a very good reason to do so.
Low scores, then, must be addressed urgently by any service provider interested in complying with good practice. In other situations, it will be hard for many services to achieve universally high scores. However, careful examination of the requirements will almost always reveal that with planning and iterative adjustments to practice, they are attainable over a period of time. Contrast this approach with one where a complex set of process changes are imposed on a service, despite whatever systems might be in place to build upon.

3.2 Formulating responses

Once priority areas for improvement have been determined, decisions about responses should be made.

3.2.1 Defining new targets

The first step is to define the targets. Sometimes these are referred to as goals or objectives. The target should include an objective and a clear target. The objective is the real world change you want to see according to the scores. The target is a meaningful outcome that reflects that objective. These targets should be pursued to improve the scores in a way consistent with your vision and mission.

3.2.2 Defining new measurements

Once the objectives and targets are defined, we need to define how achievement on those objectives and targets will be defined. The first is the indicator. Sometimes this might be referred to as a variable or an ‘objectively verifiable indicators’. For instance, this might be a percentage, a raw number, a number on a standard survey form or qualitative responses. The source of verification is the tool, instrument, process or anything else that derives that indicator. A sample is given in Table 1.

3.2.3 Defining new responses

Selecting the activities that are realistic within the organisational capacity is the next step. Importantly, there might be many activities for every objective, and many objectives for each scorecard and subsection. Consequently, a long list of activities for the strategic development cycle may result. That might seem like a problem – but recall that for ongoing improvement without a systematic approach, those same activities would have been required, but might not have been as clear and resulted in the need to react to emerging problems rather than a more pro-active approach as is promoted by using the RMS. Once a list of strategic actions is defined, they should be implemented.
<table>
<thead>
<tr>
<th>Targets</th>
<th>Measurements</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>Targets</td>
<td>Indicators</td>
</tr>
</tbody>
</table>
| Cleanliness in the facility is improved | A routine cleaning procedure is developed and implemented. | - Cleaning procedure has been documented  
- Person/s allocated as responsible for cleaning  
- Cleaning products are available  
- Subjective feedback on cleanliness improves | Procedure documents  
Stock takes  
Client satisfaction forms | - Adjust cost calculation to include cleaning and cleaning products  
- Write a cleaning procedure  
- Allocate responsibility  
- Procure cleaning supplies | Manager, Procurement manager |

Table 1 - Sample responses to an identified problem

Targets, measurements and responses are made in response to an observable problem. In this case, the observable problem was a low score on ‘Cleanliness’, in scorecard 6. The evaluation of the problem has highlighted that problems with general cleanliness in the facility have been observed. They might have been observed by staff or the client, through feedback (or it might just be an obvious problem). Because this is an important issue, the managers have decided to prioritise this problem, described targets, an indicator and verification, as well as specific activities. Responsible persons are described. These are then all described in the ‘Planning detail’, along with all the other responses.
4 The RMS for strategic development

Now that we understand the underlying causes of the issues identified in the scoring and defined new targets, how to measure our achievement of those targets, and defined responses to achieve the targets, we need to decide which responses are the highest priority, the most appropriate, realistic and fit you’re your organisation’s vision and mission.

4.1 A simplified quality management process

In addition to the scoring system to orient service managers to recognised quality indicators for rehabilitation services, along with detailed, narrative descriptions on what they mean and how to interpret them, this system offers a step-by-step approach to strategic development.

It is not the purpose of the RMS, or any other external pressure, to dictate the vision or mission of an organisation. The purpose of this section is to describe how the vision and mission of an organisation influences the way this management system should be used and interpreted.

4.2 Organisational vision

While the overall vision of a rehabilitation service should not change its compliance with core indicators, defined by relevant policies, guidelines and examples from good practice, they are essential during a strategic review of current scoring.

Having a clearly agreed vision can help orient and prioritise actions to address limitations seen during the scoring process.

4.3 Organisational mission

Your mission should describe the things you can and will do to achieve the vision you have set out. Defining a mission should orient the kinds of activities that are relevant to your organisation, and may require amendments to the quality indicators. For instance, a service that is intended for children should not be compelled to provide services for adults. There may be geographical restrictions to your service catchment. Depending on the mission of the service provider and on local requirements, legislation or other legal requirements and the particular requirements associated with funding streams, the mission will influence the importance of some standards to your service and therefore the strategic development process.
4.4 The relationship between the RMS and other analytical frameworks in rehabilitation services

Quality service delivery in rehabilitation is influenced by performance factors at all levels – sector level, service level and clinical level. There are indicators and measures to evaluate sector and clinical level performance. The RMS provides a link between the two. (See figure 7)

Because the RMS is not intended to measure clinical performance, it can be used with other frameworks like clinical outcomes tools, quality assurance audit processes, and so on. Sometimes there might be overlap. The RMS may give structure to how different tools are used. For example, there might be tools for procurement or cost calculation – these would be recognised with good scores on the RMS, and their link with other processes would be made clear.

Figure 8 - Understanding quality at different levels of rehabilitation services

The RMS is for the service level. There are other processes to understand the quality of rehabilitation services at the overall sector level. At the clinical level – there are hundreds of different processes.
4.5 Understanding the use of the RMS in a large rehabilitation program

Where a whole rehabilitation program is being examined, the RMS can be used to prioritise activities at different centres, look at shared weaknesses, or to have a baseline assessment. The use of the RMS will depend on the monitoring and evaluation of any project that is being implemented to develop the services and overall rehabilitation program.

Suggested implementation plan for the RMS

A suggested implementation might consist of:

1. **A short sensitisation** of relevant stakeholders. This might be a few hours of showing results on the RMS from other services, showing improvement, hearing testimonials from other users.

2. **Exposure visit**: Once there is general awareness of the RMS and an agreement that it might be helpful to the stakeholders, exposure to other services using the RMS might be helpful. This can sometimes happen within a country, or in a region. Obviously this is highly dependent on resources available, and is only optional. This could be combined with some training or another activity, to maximise use of the investment.

3. **A pre-scoring workshop**: This would involve looking at other management processes, getting documentation together, timetabling and logistic arrangements for a scoring. This might take about a half day or a day.

4. **LITE scoring**: Even for services interested to do a full scoring, it is recommended to start with the LITE scoring, to quickly orient users to the system and to the overall issues and strengths in the service. LITE scoring usually takes about a day.

5. **FULL scoring**: After LITE scoring, it will be easy to move to full scoring. Combined with the step-by-step training, a full scoring can take about 3 days. This sounds like a long time, but it can be broken up with different activities, split between groups, or done over a few weeks, a day at a time.

6. Once scoring has been done (whether LITE, full, or some partial version) a **planning workshop**, possibly divided into sections, can be done over some days. This should prioritise which areas to target for change. The timeframe can be determined, resources allocated, and links to resources and experts found. This can take between a day and several days, but should be planned routinely to review progress, update scores, and so on.

7. **Implementing change**: Step by step, drawing on available resources, implementing change can take months. The important thing is to demonstrate consistent improvement, targeted at the main areas of
weakness, and building on strengths. It is impossible to define a time frame for this, but ideally, a few times a month, managers and staff (and other stakeholders) will review scores, and make a plan for the next few weeks or a month to improve systems and practices, and to document them.

8. **Re-review**: After an agreed time (ideally 4-6 months at the start), the process should be repeated and reviewed.
5 Step by step training on RMS

5.1 First scoring and planning

Before introducing the RMS process and scorecards for the first time, it is recommended to address the following points with relevant stakeholders:

- **Alignment and leadership**
  a. Why are we implementing standards, what are the expectations?
  b. What priorities does the team want to handle, with what resources?
  c. How can technical partners help?

Furthermore, specific training for managers to further strengthen essential skills on leadership might be necessary to ensure an optimal implementation of the RMS:

- Setting priorities, defying objectives and planning
- Communication skills, and how to build motivation within the team.

Finally, a step by step training on the RMS scorecards and process:

- Amendment and adaptation of standards if necessary
- Scoring and definition of action plans.

Introduction modules and scoring should take 5 to 6 days and involve managers and any persons who will contribute actively to scoring and planning, from administrative, to clinical and support staff.

Training material is available both for the scoring process and for leadership and alignment.

5.2 Follow up and implementation of action plans

Support to the continuous strategic planning process and implementation of activities for change can be provided in several ways as already mentioned:

- Direct coaching and supervision at the time of re-scoring and revision of planning at the service level; this might include support in budget planning and fund raising for allocation of resources for quality improvement when required
- Establishment of technical committees in country for continuous overview and support, engaging relevant government representatives, service providers and users
- Exposure visits to countries and services who are implementing the RMS
- Access on GRAASP to community of practice on the RMS – documents, policies, guidelines and other tools developed and utilized in other countries in support to the quality assurance process. Contact: Chiara Retis cretis@handicap-international.org
The Rehabilitation Management System: Evaluating and planning physical rehabilitation services

This practical guide explain how to implement a rehabilitation management system step by step.

The overall purpose of the Rehabilitation Management System (RMS) is to assist rehabilitation service providers in effective and strategic management of their services in order to provide the highest quality care in the most sustainable manner. To achieve this, the RMS a) summarises the literature concerning good practice, legal requirements and agreed standards and guidelines, b) facilitates internal examination of compliance with those guidelines, and c) helps to systematise improvement of those areas.

The RMS assesses the performance of a rehabilitation service in 6 core areas: Service Users, Service Outputs, Staff, Equipment & Supplies, Finances, and Management Processes. The RMS is scored using an excel spreadsheet (available on GRAASP and SkillWeb) with 3 main parts:
• A dashboard, to orient users to the RMS process
• Summary indicators and ‘Summary planning’ worksheet – used in LITE scoring
• Detailed scorecards and ‘Planning detail ‘worksheet – used for Full scoring.