Ultrasound Guided Sclerotherapy

Diagnose venous disease and treat superficial venous incompetence with injected sclerosants under ultrasound guidance

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INTRODUCTION

This standard is for practitioners who need to diagnose and investigate lower limb venous diseases prior to using Ultrasound Guided injections of sclerosant for the treatment of superficial venous incompetence. It has been developed by Australasian College of Phlebology (ACP) doctors working in the Phlebology modality***** 'Ultrasound Guided Sclerotherapy' (UGS) to provide an assessment tool for doctors in training towards their ACP Fellowship, and for recertification of ACP certified doctors under the ACP Maintenance of Professional Standards (MOPS) programme.

The criteria and outcomes of this standard consider competency in terms of interpersonal, diagnostic and management interactions. It is strongly procedure based, while at the same time focusing on the systems and processes required to ensure a safe and responsive service is provided.

*****ACP defined modalities of Phlebology:

Level 1	Direct Vision Sclerotherapy
Level 2	Ultrasound Guided Sclerotherapy
	Endovenous Ablative techniques
	Ambulatory Phlebectomy

1. Scope of Application

1.1. This Standard is copyright to ACP.

1.2 It is used by certified ACP Phlebologists in their role as supervisors to assess trainee competence in using UGS to diagnose and treat superficial venous incompetence in legs. In addition it is used on an ongoing basis, as a reassessment tool to ensure that doctors continue to meet the standard required in delivering this service to patients

1.3 This standard is used periodically during and at the end of the training period. It is also used by trainees and ACP certified doctors working in the modality of Ultrasound Guided Sclerotherapy to self-monitor their own performance.

1.4 Assessment as competent in this standard is not sufficient for doctors to gain ACP certification. Before being considered for Fellowship of ACP trainees must have completed both the ACP Part 1 training and examination programme, and completed the registrar training programme for advanced phlebology.

2. Purpose

Practitioners credited with this standard are able to establish patient needs, communicate and manage risks and deliver safe, timely and appropriate ultrasound guided sclerotherapy to treat superficial venous incompetence, which meets their patients' expectations.

3. Context/Environment/Service Delivery

3.1. Australia

The licencing requirements for private hospitals, of which day procedures and are a part, differ in each State and Territory. It is the obligation of each practicing member of ACP to comply with the licensing standards outlined in the Acts and Regulations of their state or territory.

In summary:

New South Wales

In NSW private hospitals and day procedure centres are licensed under the *Private Health Facilities Act 2007*

Private health facilities must meet all the general licensing standards set out in Schedule 1 of the *Private Health Facilities Regulation 2010* and any associated licensing standards that apply to each class of the facility as detailed in Schedule 2 of the Regulation. Licensing is overseen by the Private Hospital Unit within NSW Ministry of Health.

Victoria

The Department of Health is responsible for the regulation of private hospitals and day procedure centres under the *Health Services Act 1988* and the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*.

Queensland

Private hospitals within Queensland are licensed under the *Private Health Facilities Act 1999*. Queensland has a Clinical Services Capability Framework for Licensed Private Health Facilities that specifies support services, staff profiles and minimum safety standards that should be met by private health facilities to ensure safe and appropriate supported clinical services.

Additional reporting requirements are imposed on licensed private hospitals through the *Health Quality and Complaints Commission Act 2006*.

In addition to these quality and safety reporting requirements, private hospitals in Queensland are required to provide data to the Queensland Health Admitted Patient Data Collection (QHAPDC) and to the Queensland Health Monthly Activity Collection (QHMAC).

South Australia

Within South Australia, the *Health Care Regulations 2008* and the *Health Care Act 2008* specify the regulations that govern the licensing of private hospitals.

Western Australia

Private hospitals and day hospitals are licensed within Western under the legislative framework provided by the *Hospitals and Health Services Act 1927*, the *Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987*, the *Hospitals and Health Services (Day Hospital Facility) Determination 2005*, and the *Hospitals and Health Services (Day Hospital Facility) Determination (No. 2) 2005*.

Tasmania

In Tasmania, private hospitals and private day hospitals are licensed under the *Health Services Establishments Act 2006.*

Northern Territory

In NT, private hospitals are licensed under the *Private Hospitals Act*. This Act specifies the requirements for licensing and arrangements for the management and inspection of private hospitals.

Australian Capital Territory

In the ACT, private hospitals are licensed under the *Public Health Act 1997*.

3.2. New Zealand

Premises used by practitioners in delivering this service must comply with the relevant sections of NZS 8164:2005 Day-Stay Surgery and Procedures, and NZS 8165:2005 Rooms/Office-based Surgery and Procedures.

The clauses in the NZS standard relevant to the delivery of this service are those pertaining to 'Office-based surgery and procedures' i.e. the equipment/facilities of an operating theatre are not required.

These clauses require persons delivering this service to meet both facility requirements and those pertaining to consumer/patient rights, consent, Treaty of Waitangi (NZ), cultural safety issues, and complaints. In addition management specifications relating to clinical management and personnel, quality and risk management including Infection control, consumer/patient selection, clinical emergency response and transfer, clinical records, and medicine management must be met in the delivery of this service.

The facility requirements for UGS include specifically, Section 5.5 Power and Lighting requirements including Notes 1 & 2:

Note 1. All areas where it is intended to use mains operated equipment for patient treatment or diagnosis meet the minimum requirements of Body Protected Areas, as specified in AS/NZS 3003.1:2003: Electrical installations – Patient treatment areas of hospitals and medical, dental practices and dialyzing locations. The provision of a residual current device (RCD) is an appropriate means of compliance.

Note 2. All body Protected Areas shall have an In-service Testing Programme to AS/NZS 3003.1:2003: Electrical installations – Patient areas of hospitals and medical and dental practices – testing requirements.

4. Entry Requirements

4.1 Doctors registered with the Australia or NZ Medical Council who meet all the following criteria:

Membership of ACP

Hold a pass in Level 5 or higher Advanced Cardiac Life Support (ACLS) Successful completion of part 1 ACP Phlebology exam

Are working under the supervision of a registered Fellow of ACP OR are enrolled in an accredited ACP registrar training programme.

4.2 Doctors registered with the Australia or NZ Medical Council who are Fellows of ACP undergoing recertification.

5. References

Australia:

Private Hospital Data Collection Final Review, Department of Health. Australian Government,
http://www.health.gov.au/internet/publications/publishing.nsf/Content/

NSW Ministry of Health, Licencing of Private Health Facilities, http://www.health.nsw.gov.au/Hospitals/privatehealth/Pages/licensing-of-private-health-facilities.aspx

Private Health Facilities Regulation 2010, NSW Government www.legislation.nsw.gov.au

Private Health Facilities Act 2007 No 9, NSW Government,
Current version for 2 November 2015 to date, www.legislation.nsw.gov.au

NSW Ministry of Health, Policy Directive: Clinical Procedure Safety, 2014 Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013, www.legislation.vic.gov.au

Health Services Act 1988. Victorian Government.

Queensland Government Private Health Facilities Act 1999, https://www.legislation.qld.gov.au

Monthly Activity Collection Manual, Private Facilities. Queensland Health, July 2010.

Health Care Regulations 2008 and the Health Care Act 2008, South Australia Health, South Australia Government, http://www.legislation.sa.gov.au

Hospitals and Health Services Act 1927, updated 2010, Western Australia Health, Western Australia Government, http://www.slp.wa.gov.au

Private Hospitals Act, Department of Health and Families, Northern Territory, Northern Territory Government, http://www.austlii.edu.au/au/legis/nt/consol_act/pha215/

Health Services Establishments Act 2006, Department of Health and Human Services, Tasmania, Tasmanian Government, http://www5.austlii.edu.au/au/legis/tas/consol_act/hsea2006295/

Public Health Act 1997, ACT Health, ACT Government, http://www.legislation.act.gov.au

New Zealand:

NZS 8164:2005 Day-Stay Surgery and Procedures.

NZS 8165:2005 Rooms/Office-based Surgery and Procedures. ACP/NZCAM Maintenance of Professional Standards (MOPS) Programmes.

'Training Programme towards NZCAM Membership and Fellowship Certification' including:

ACP Protocols: 'Training', 'Informed Consent', 'Infection Control', 'Management of waste and hazardous substances', 'Clinical Records', 'Medicine management', 'Local and regional anaesthesia', 'Clinical emergency response and transfer, surgical emergencies, resuscitation, and referrals', 'New procedures/products Approvals', 'Advertising', 'Ethics'.

AND Modality specific Training Curriculum.

TAPS (Therapeutic Advertising Pre-vetting system) Guideline No. 16 'Advertising by Healthcare Professionals Appearance Medicine and Eye Clinics' (NZ)

Medical Practitioners Act (1995) (NZ) Medicines Act 1981(NZ) Medicines Regulations 1984(NZ) Medsafe guidelines (January 2001) (NZ) Health Practitioners Competency Act (Sept 2004)

6. Risk Management

6.1 ACP requires written informed patient consent before UGS.

6.2 The ACP approved sclerosants covered by this standard are

- Sodium tetradecylsulphate (STS) (Fibrovein™)
- Polidocanol(Laureth-9)
- supplied as either Sclerovein™(in NZ only) or as Aethoxysklerol™

6.3 Duplex/Doppler Ultrasound equipment used in delivering this standard must include a high frequency linear array probe with colour flow and Doppler capabilities.

6.4 Under this standard, liquid and foam sclerosant formulations are approved within the maximum allowable limits (Refer 6.5, 6.6, and 6.7 below).

6.5 Under the NZ Medicines Act, Foam is an unapproved use of an approved/or unapproved medicine (STS is the only approved sclerosant) but permitted when administered by a Registered Medical Practitioner provided full written informed consent has been given by the patient.

6.6 This standard restricts the use of STS(3%) to a maximum of 4 mls liquid per day (≡ .12g per patient per day).

6.7 Use of polidocanol must not exceed 2mg/kg body weight per treatment day.

6.8 The minimum resuscitation equipment required is:

Oxygen, intravenous fluids, adrenalin, blood pressure and cardiac monitor, pulse oximetry, defibrillator, and suction.

7. Special Notes

7.1 Notification of Information to Supplier of UnApproved Medicines (NZ Only).

In New Zealand, the following sclerosant is listed as a Prescription Medicine with the Ministry of Health.

- <3%STS (Fibrovein™). This is only listed as a Prescription Medicine if it is supplied in 2 ml ampoules. 3% STS supplied in 5 ml vials are unapproved and can only be used under Section 29 (see below).

All other sclerosants are unapproved at this time. However under Section 29 of the Medicines Act 1981, unapproved medicines can be supplied to a medical practitioner for administration to their own patients.

It is a mandatory requirement for doctors who have been supplied with medicines under Section 29, to furnish the supplier at the end of each month, with the following information:

- Name of patient
- Dose form and strength
- Date medicine was supplied

At the end of each month, the supplier of an unapproved medicine must then notify Medsafe of the following:

- Proprietary name and trade name of product.
- Dose form
- Month and year of supply.
- Name of supplier.

The patient details are recorded and kept by the supplier, and must be available for audit from Medsafe.

The doctor must inform the patient, as part of the consenting procedure that their details will be given to the supplier and will be available for audit from Medsafe.

7.2 Advertising in New Zealand

- Direct to consumer advertising for treatment of varicose veins must not mislead the public.

- Practitioners must not front, speak or appear in advertisements for medical clinics as this would be regarded as 'healthcare professional endorsement by implication' (Section 58 of the Medicines Act (1981).

7.3. Advertising in Australia

- Section 133 of the National Law prohibits advertising that:
  - is false, misleading or deceptive or is likely to be so
  - offers a gift, discount or other inducement to attract a user of the health service without stating the terms and conditions of the offer
  - uses testimonials or purported testimonials
  - creates an unreasonable expectation of beneficial treatment, and/or encourages the indiscriminate or unnecessary use of health services.
- These guidelines cover all types of advertising, including social media, blogs and websites.

See AHPRA Guidelines for Advertising Regulated Health Services under Codes, Guidelines and Policies, http://www.medicalboard.gov.au

7.4. Consent

Written informed consent is obtained following the ACP Informed Consent Protocol.

8. Definitions

ACP Australasian College of Phlebology

UGS Ultrasound Guided Sclerotherapy

STS Sodium Tetradecyl Sulphate

Varicose vein Any vein >2mm with demonstrated retrograde flow indicating incompetence.

SFJ ≡ Sapheno-Femoral Junction

GSV ≡ Great saphenous vein

SSV ≡ Small saphenous vein

SPJ ≡ Sapheno-Popliteal Junction

SVT ≡ Superficial venous thrombophlebitis

CEAP Classification (basic):

i.e. C = Clinical E = Etiologic A = Anatomic P = Pathophysiologic

1.Clinical classification

C_0 No visible or palpable signs of venous disease

C_1 Telangiectasies or reticular veins

C_2 Varicose veins

C_3 Edema

C_{4a} Pigmentation or eczema

C_{4b} Lipodermatosclerosis or atrophie blanche

C_5 Healed varicose ulcer

C_6 Active venous ulcer

S Symptomatic, including ache, pain, tightness, skin irritation, heaviness, and muscle cramps, and other complaints attributable to venous dysfunction

A Asymptomatic

2.Etiologic classification

Ec congenital

Ep primary

Es secondary (postthrombotic)

En no venous cause identified

3.Anatomic classification

As superficial veins

Ap perforator vein

Ad deep veins

An no venous location identified

4.Pathophysiologic classification

Pr reflux

Po obstruction

Pro reflux and obstruction

Pn no venous pathophysiology identifiable

Definition of Consumer For the purposes of this Standard, patient refers to the consumer.

Definition of Phlebologist Fellow of ACP whose training includes vascular ultrasound, who is providing treatment to patients under this standard.

9. Attachments

Appendix 1 'CP Ultrasound Guided Sclerotherapy' - Clinical procedure (CPUGSJuly2010Vers2.doc).

STANDARD ELEMENTS AND CRITERIA

1 CONDUCT INITIAL CONSULTATION AND CLINICAL ASSESSMENT

1.1 Information regarding venous incompetence, diagnosis and treatment alternatives

Outcome: The patient is fully informed of the nature of venous incompetence, understands the diagnostic process necessary to confirm the cause, and that the treatment alternatives available will depend on the diagnosis.

Criteria

1.1.1 The patient is assessed in person by the treating practitioner at the service delivery location.

1.1.2 The patient's expectations are discussed and documented.

1.1.3 The patient is informed that treatment of venous incompetence is a two stage process which comprises diagnosis followed by clinically appropriate treatment options.

1.1.4 Patient is given adequate opportunity to ask questions.

1.1.5 The patient understands that after diagnosis, s/he will be asked for written consent to authorise the treatment, and is offered more time to consider the treatment before proceeding if s/he is unsure in any way.

1.2 Patient assessment and initial consultation records

Outcome: A full medical history and clinical assessment of the patient is documented and discussed with the patient; contra-indications are excluded, and suitability for diagnostic and subsequent treatment confirmed.

Criteria

1.2.1 The following patient information is documented:

Age

Onset of vein problem

Onset of symptoms if appropriate

Past medical /surgical history and associated complications including thrombophilia, patent foramen ovale(PFO) and migrane with aura.

Previous vein treatment

Family History of vein disease, thrombophilia, coronary artery disease, peripheral vascular disease

Allergies

Current medications including oral contraceptives and hormone replacement therapy

Smoking history

Obstetric history

1.2.2 Pre-operative blood tests appropriate to the treatment are ordered.

1.2.3 The CEAP clinical classification of the chronic venous insufficiency is accurate and documented.

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1.2.4 Ultrasound guided sclerotherapy is indicated for patient presenting with symptoms or signs of venous disease. Where clinically relevant, sclerotherapy is recommended for the following types of veins* :

Incompetent saphenous veins

Tributary varicose veins

Incompetent perforating veins

Reticular varicose veins

Residual and recurrent varicose veins after previous interventions

Varicose veins of pelvic origin

Varicose veins(refluxing veins) in proximity of leg ulcers

Venous malformations

*Modified version, Recommendation 1, European Guidelines for Sclerotherapy in Chronic Venous Disorders, Phlebology, 2013.

1.2.5 The following absolute contra-indications are

Allergy to proposed sclerosant

Acute Deep Vein Thromboembolism

Permanent neurological adverse effect from a previous sclerotherapy intervention

Known symptomatic cardiac septal defect e.g. PFO or atrial septal defect

1.2.6 The following relative contra-indications are identified, risk/benefits evaluated, and any modifications clinically indicated are reflected in the dosage or method used, and agreed with the patient.

Severe peripheral vascular disease

High risk of venous thromboembolism

Acute Superficial Venous Thrombophlebitis

Pregnancy

Breastfeeding within 48 hours

Oral contraceptives

Hormone replacement therapy

Neurological events or disturbances, including migraine, following previous sclerotherapy

Potential for lack of compliance

Travel> 4 hours within the last 2-4 weeks.

1.2.7 Clinical examination identifies all visible secondary complications present which result from venous incompetence enabling a CEAP classification.

1.2.8 The patient is informed of the practitioner's initial assessment of the cause of the problem, and an anticipated course of treatments is explained, based on the assumption that the diagnostic process will confirm the practitioner's assessment.

1.2.9 A written estimate of cost for the anticipated course of treatments (to be confirmed post diagnosis) is given to the patient.

1.2.10 Consent for photography is obtained prior to pre-treatment photographs being taken.

2 MAP DEEP AND SUPERFICIAL VEINS WITH DUPLEX/DOPPER ULTRASOUND

Outcome: Cause and location of venous incompetence is identified and recorded, superficial thrombophlebitis and deep vein thrombosis is excluded, and suitability for subsequent treatment is confirmed.

Criteria

2.1 Incompetence in the superficial or in the deep vein system is identified and its location recorded in relation to an anatomical landmark.

2.2 All contributing sources of venous incompetence causing visible post-surgical recurrences are identified and their location recorded.

2.3 Any pathology relevant to the venous incompetence or in close proximity to the incompetent veins is identified and its nature and location recorded.

2.4 A documented pictorial scheme/map records extent and location of incompetence in the venous system including its source i.e. saphenous trunks, tributary vessels, perforators, deep vein system.

2.5 If present, Acute DVT is treated as an absolute contraindication, its extent measured in terms of its length in the vein and a management plan is initiated to minimise the risk of venous thromboembolism.

2.6 The diameter of each incompetent vessel at intervals throughout its length is accurately measured and recorded, with the GSV measured at the Sapheno-Femoral junction, at mid-thigh and knee; and the SSV measured at the Sapheno-Popliteal junction and mid-calf.

3 ESTABLISH AND AGREE ON A TREATMENT PLAN

Outcome: The patient is fully informed of the diagnostic results, the suggested treatment plan, any potential risks, and results expected to be achieved at the end of the treatment period. The recommended treatment plan is clinically appropriate, and is the best option to addresses patient's needs. Written consent is obtained.

Criteria

3.1 Findings are discussed with the patient, and treatment options available and recommended are clinically indicated and achievable within patient's expectations.

3.2 Risks of proposed treatment and possible actions in the event of adverse outcomes are explained.

3.3 If treatment is indicated, the interval between diagnosis by Duplex/Doppler ultrasound and treatment is no more than one year or more frequently depending on clinical circumstances.

3.4 Instructions are given for pre-operative requirements and these are appropriate for the treatment method proposed.

3.5 The patient understands that in New Zealand if an unapproved sclerosant is selected, his/her name and treatment details are required under Section 29 of the Medical Practitioners Act, 1981 to be recorded and forwarded to the supplier. The patient is informed that this information is as follows:

- Name of patient
- Dose form and strength
- Date medicine was supplied.

3.6 The patient is informed that in New Zealand if an unapproved sclerosant is selected, his/her details may be provided to Medsafe for audit purposes.

3.7 Written informed consent for the proposed treatment is obtained following the ACP protocol 'Informed Consent', and is signed by both phlebologist and patient.

3.8 A copy of the diagnostic findings and proposed treatment plan is sent to the patient's GP and the referring practitioner.

4 INJECT VEINS WITH SCLEROSANT UNDER ULTRASOUND GUIDANCE

Outcome: Sclerosis of target vessels contributing to venous incompetence is achieved in a manner and timeframe which minimises risk and maximises achievable patient expectations.

Criteria

4.1 Product concentrate is within the expiry date of the batch and is stored correctly according to manufacturer's specifications.

4.2 Containers of stored sclerosant used for injection are legibly labelled with correct concentration for purpose.

4.3 Where product requires dilution, sterile preservative-free saline is used.

4.4 Sclerosant concentration, formulation and delivery method minimises venous thromboembolism, superficial thrombophlebitis, and anaphylaxis incidents to < 0.02%.

4.5 Maximum volume of 3% STS injected as a liquid is 4 mls (≡ .12g per patient per day).

4.6 For any detergent sclerosant, foam dilution range is between 1 part liquid and 1 part appropriate gas (air, CO2, O2), to 1 part liquid/4 parts appropriate gas.

4.7 The maximum volume of 3% STS used as foam does not exceed 4 ml liquid per day irrespective of dilution used.

4.8 A new needle and syringe is used for every penetration of the multidose vial containing sclerosant.

4.9 The maximum dose of polidocanol is 2 mg/kg patient body weight per day regardless of the liquid concentration or liquid/ambient air dilution.

4.10 The total volume of sclerosant foam injected in one day should not normally exceed 20ml regardless of the ambient air dilution used for STS or polidocanol.

Truncal veins e.g. GSV: In general, a maximum of 10ml per leg should be adhered to. Care should be taken not to inject large boluses of foam near the junctions. Due to concerns about air embolus, large single volumes should not be used in the proximal trunk veins. We recommend careful administration of sclerosant in small aliquots of 0.5 to 3ml per injection point. We recommend against 'infusion' of foam from a single entry point into saphenous trunks and recommend multiple small boluses.

Tributaries (once trunks treated): Dose depends on sclerosant concentration, gas used, vein treated. In general, a maximum of 10ml per leg should be adhered to. However once truncal veins have been closed, in very large tributaries volumes can be increased to 15-20ml (provided foam is not noted on ultrasound to extend into the deep system) and no more than 20ml is injected for the session i.e. if larger doses are used the maximum foam injected in that session is 20ml regardless of whether one or two legs are treated.

4.11 Further treatment which is clinically appropriate for the patient is offered in the event of current treatment session being terminated as a result of sclerosant volume and dosage limits being reached.

4.12 Correct placement and uniform coverage of sclerosant in target vessels is achieved and is confirmed by ultrasound guidance to monitor the process of sclerosis.

4.13 Patient is fitted into correctly sized Class 2 compression hosiery immediately post treatment.

5 PROVIDE POST TREATMENT ADVICE TO PATIENT AND RECORD TREATMENT DETAILS

Outcome: Treatment outcomes are optimised in the recovery period and patient safety and welfare followed post treatment.

Criteria

5.1 The patient is reminded of the post-operative requirements

5.2 All possible symptoms which may be of concern post treatment are described and the patient is instructed to contact practitioner urgently if any arise.

5.3 Practitioner follow-up of patient concerns is appropriate and in a timeframe that minimises risk to patient.

5.4 Contact details of the treating practitioner or deputy are provided.

5.5 Perioperative Travel recommendations:

Pre operatively.

-Patient is advised to avoid continuous air or vehicular travel > 5 hours for 1 week prior.
-If vehicular travel > 5 hours necessary, advise patient to have regular breaks and mobilise.
-If travel necessary, consider anticoagulation and if long distance travel of >5 hours occurs within one week preoperatively, check for DVT

Post operatively

-Given risk of DVT associated with flying, we recommend no overseas travel for flights >5 hours for four weeks. If necessary, flights < 5 hours are acceptable, if the patient is mobilising.
-It is common to have phlebitis 4-6 weeks post op. The patient may want to delay long haul travel until after this time because of difficulties with follow up.
-If patient is going to travel within first week post op, assess DVT risk and if appropriate consider anticoagulation.

5.6 An assessment of the success of treatment is made by examining the patient with duplex ultrasound scan within 1-2 weeks of the completion of treatment, as well as:

- within 6 weeks to 3 months for assessment of residual reflux
- 6 months to 1 year post treatment

5.7 At each assessment the findings are recorded and discussed with the patient and include:

1. Success of treatment including resolution of symptoms
2. Degree of sclerosis and any recanalisation
3. Any complications
4. Patient satisfaction

5.8 Where clinically indicated, further appropriate treatment is offered, or referral made.

5.9 Treatment and assessment records are complete and include:

1. Leg and vessels treated
2. Sclerosant type, dosage or concentration used
3. Type and size of compression hosiery applied and recommended time of application
4. Post treatment assessment of resolution of symptoms
5. Any adverse effects or interventions
6. What further treatment is indicated/offered (if any) after post treatment assessments, any referral made, and whether the treatment plan has been completed.