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Australasian Faculty of Rehabilitation Medicine

The Royal Australasian College of Physicians

Australasian Faculty of Rehabilitation Medicine (AFRM)

Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals

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Introduction

Purpose and Intent of this document:

The purpose of these standards is to guide RACP Fellows, government, health service planners and administrators in their decision making about the provision of inpatient adult rehabilitation medicine services in public and private hospitals. This document builds upon previous versions of The Australasian Faculty of Rehabilitation Medicine (AFRM) Standards documents and incorporates updated best practice and consensus guidelines into one single document, which can be used as a reference.

Application of these Standards to inpatient rehabilitation programs:

The AFRM is committed to the provision of comprehensive, high quality care in the services in which its Fellows practise. This document on Standards for Adult Rehabilitation Medicine Services in Public and Private Hospitals refers only to specialist rehabilitation medicine units. (In particular, it is stressed that these Standards do not refer to medical rehabilitation programs conducted by other physicians who are not specialists in rehabilitation medicine). The Standards do not apply to other restorative health or healthcare programs containing rehabilitation if they do not fulfil the criteria established by the AFRM for a specialist Rehabilitation Medicine service (see Governance; sections 1.2 – 1.8).

These Standards relate to the provision of inpatient rehabilitation programs only and are to be considered general standards. While also applicable to the provision of tertiary level, highly specialised, inpatient rehabilitation programs (for example, brain injury, spinal cord injury or burns rehabilitation), these tertiary rehabilitation programs may have requirements which are beyond the scope of this general Standards document.

AFRM Standards for the provision of Paediatric Rehabilitation Medicine Inpatient Services in Public and Private Hospitals are described in a separate document[1].

Application of these Standards to other rehabilitation settings:

Rehabilitation medicine physicians also provide programs outside of traditional inpatient rehabilitation units (for example, in various community-based settings; as day hospital programs, or; in acute care settings such as an acute stroke unit or an ‘in-reach rehabilitation team’ providing rehabilitation services to patients within acute wards of the hospital). These Standards, while not designed specifically for use in these alternate settings, can nonetheless be used as a guide. Please refer to the AFRM Ambulatory Standards document for further information on ambulatory rehabilitation medicine services[2].

Future development of the AFRM Standards:

Over time, it is the intention of the AFRM to develop Standards for use across a range of care settings and programs as newer service models become more established.

Standards

These Standards cover the following seven aspects of service provision:

1. Governance

A specialist rehabilitation medicine service will be under the direction of a rehabilitation medicine physician (Fellow of the AFRM) and provides comprehensive, patient-centred interdisciplinary care. This care is evidenced by the establishment of achievable treatment goals, the periodic assessment and documentation of the functional status of patients, the occurrence of regular case discussion amongst treating practitioners, and attention to the optimal management of concurrent medical problems and psychosocial issues. The primary objective of care is to help patients achieve their optimal level of functioning and participation in society.

2. Staffing

Staffing includes a range of team members (medical, nursing, allied health and support staff) with an appropriate skill base and training to provide comprehensive, contemporary programs of care to address the impairments, activity limitations and participation restrictions present in the patients admitted to the rehabilitation medicine service. There are sufficient team member hours available to allow each patient to receive an individualised nursing and allied health program of adequate intensity to meet their needs, delivered in a way that optimises the effectiveness and efficiency of the rehabilitation program.

3. Facilities and equipment

The facilities and equipment are both adequate and appropriate for the rehabilitation needs of patients and are also able to provide a safe learning environment for retraining in lost skills.

4. Policies and procedures

There is documentation of policies and procedures to ensure safe, appropriate, accountable, effective and measurable improvement in the patients involved in rehabilitation programs.

5. Quality improvement and risk management activities

The service has a quality improvement and risk management framework with appropriate single discipline and multidisciplinary activities and projects addressing consumer engagement, access, appropriateness, effectiveness, safety and efficiency.

The service submits data to the Australasian Rehabilitation Outcomes Centre (AROC) and regularly reviews its performance against benchmarks established by AROC.

The service participates in an accreditation process as provided by an external hospital accreditation organisation recognised in Australia or New Zealand.

6. Education and Teaching

The service is actively engaged in continuing education, teaching and continuing professional development.

7. Research

The service promotes the importance of and is actively engaged in research activity.

Demonstrating the Standards

1. Governance

A specialist rehabilitation medicine service under the direction of a rehabilitation medicine physician (Fellow of the AFRM) provides comprehensive, patient-centred interdisciplinary care. This care is evidenced by the establishment of achievable treatment goals, the periodic assessment and documentation of the functional status of patients, the occurrence of regular case discussion amongst treating practitioners, and attention to the optimal management of concurrent medical problems and psychosocial issues. The primary objective of care is to help patients achieve their optimal level of functioning and participation in society.

1.1 Definitions of Rehabilitation Medicine, Rehabilitation Medicine Physician, Rehabilitation Medicine service and other rehabilitation services.

Rehabilitation Medicine is that part of the science of medicine involved with the prevention and reduction of functional loss, activity limitation and participation restriction arising from impairments, the management of disability in physical, psychosocial and vocational dimensions, and improvement of function[3].

Rehabilitation Medicine was recognised as a Principal Specialty by the National Specialist Qualification Advisory Committee of the Health Insurance Commission (Medicare Australia) in Australia in 1976 and is a Vocational Scope of Practice in New Zealand (NZ).

Rehabilitation Medicine Physicians[4]:

- are Fellows of the Australasian Faculty of Rehabilitation Medicine.
- diagnose and assess a person's function associated with disability or functional decline due to injury, illness, chronic disease or aging, to maximise their independence and improve and maintain quality of life.
- provide specialist knowledge and expertise in the prevention, assessment, management and medical supervision of a person with a disability.
- evaluate medical, social, emotional, work and recreational aspects of function
- work with children and adults using an evidence-based collaborative approach with other disciplines.
- have a unique overview of the skills and expertise of other health professionals, to develop a patient-centred, individualised treatment plan in a range of settings such as public and private hospitals, community rehabilitation centres/ clinics or the patient's home.
- Further information outlining the scope of practice of rehabilitation medicine physicians can be found in the AFRM Rehabilitation Medicine Physician Scope of Practice for Adult Rehabilitation Medicine[5] or AFRM Rehabilitation Medicine Physician Scope of Practice for Paediatric Medicine documents[6].

Rehabilitation Medicine Services are specialist units of patient care providing comprehensive rehabilitation services for inpatients, outpatients and community, with each patient's clinical management being under the supervision of a Rehabilitation Medicine Physician.

A rehabilitation medicine service aims to assist people with disability or functional decline due to injury, illness, chronic disease or aging to attain the highest possible level of independence (physically, psychologically,

socially and economically) following that incident or illness. This is achieved through a combined and co-ordinated use of medical, nursing and allied health professional skills. The process involves individual assessment, establishment of achievable treatment goals, treatment, regular review, discharge planning, community integration and follow-up of people referred to that service.

1.2 The designated rehabilitation medicine service is directed by a rehabilitation medicine physician and each patient's clinical management is under the supervision of a rehabilitation medicine physician.

1.3 The rehabilitation medicine service provides an organised system of care and is comprised of a team of clinicians from a variety of disciplines. The rehabilitation team is focussed on the patient, with the aim being to assist the patient to achieve their maximum level of functioning, independence, and participation.

1.4 The patient and the rehabilitation team work together to establish meaningful and achievable treatment goals. The progress of the rehabilitation program is measured against those goals.

1.5 There is evidence of planned, coordinated care including clear, written admission criteria and formal planned discharge procedures and liaison with community services where appropriate.

1.6 There is measurement of functional status on admission and discharge. Functional status might also be formally assessed at intervals during the inpatient episode.

1.7 There is continual evaluation of the program and its outcomes.

1.8 The designated rehabilitation medicine service is accredited by a hospital accreditation organisation recognised in Australia or New Zealand.

Other rehabilitation services:
Other rehabilitation services where patients are under the care of a medical practitioner who is not a rehabilitation medicine physician or do not meet the above criteria (1.3 -1.8) are not considered specialist rehabilitation medicine services.

2. Staffing

There is a full range of team members (medical, nursing, allied health and other staff) with an appropriate skill base and training to provide comprehensive, contemporary programs of care to address the impairments, activity limitations and participation restrictions present in the patients admitted to the rehabilitation medicine service. There are sufficient team member hours available to allow each patient to receive an individualised nursing and allied health program of adequate intensity [7, 8, 9, 10] to meet their needs, delivered in a way that optimises the effectiveness and efficiency of the rehabilitation program.

2.1 Staffing of the Rehabilitation Medicine Service

2.1.1 The staff establishment for a rehabilitation medicine service includes an adequate number of professional and support staff to allow the service to provide contemporary, evidence-based rehabilitation management in a safe, effective and efficient manner.

Staffing levels need to be reviewed regularly and particularly when new models of care, such as acute rehabilitation or in-reach rehabilitation, are introduced.

Medical staff

2.1.2 Each 10 inpatient beds within the rehabilitation medicine service should have either 0.5 FTE rehabilitation medicine physicians (Amputation, Orthopaedic, Major Trauma, Pain, Reconditioning / Restorative and other impairment groups) or 0.8 rehabilitation medicine physicians (Stroke, Neurology, Traumatic Brain Injury (TBI), Spinal Cord Dysfunction). These staffing levels are inclusive of the requirement for pre-admission assessment of patients and for routine follow-up of patients of the service.

2.1.3 Ideally inpatient services will have allocated junior medical staff (Rehabilitation Medicine trainees and other Resident Medical Officers (RMO)). Specific staffing numbers for junior medical staff will vary depending upon the casemix of the inpatient rehabilitation medicine service and the acuity of patients e.g., where the inpatient service manages patients of higher acuity, such as patients with recent spinal cord injury or acute stroke, junior medical officer numbers will need to be higher than the minimum numbers outlined at 2.1.5 (below). N.B. In this document the term RMO is used to describe all junior medical staff who are not Rehabilitation Medicine trainees.

2.1.4 As a guide, it would be expected that for every 10 inpatient beds there would be a minimum 0.5 RMO and 0.5 Rehabilitation Medicine trainees. These minimum numbers apply only to the provision of direct inpatient care (for example, attending to the individual medical needs of patients, ward rounds, case and family conferences, and some pre-admission assessments and follow-up). Where trainees undertake additional duties (for example, active involvement in community rehabilitation services, outpatient programs and assessing patients in acute care) then additional trainee hours are required to support the inpatient rehabilitation beds.

2.1.5 In some situations, a Career Medical Officer (CMO) or in NZ a Medical Officer of Specialist Scale (MOSS) may replace a RMO or trainee.

2.1.6 In the occasional situation where there is no RMO / CMO / MOSS, Rehabilitation Medicine trainees should be responsible for the day to day management of a maximum of 20 inpatients.

2.1.7 In some situations, the junior medical staff duties may be covered by an additional allocation of rehabilitation medicine physician time.

2.1.8 Each rehabilitation medicine service which has Rehabilitation Medicine trainees must obtain accreditation[11] with AFRM as suitable for advanced training in rehabilitation medicine.

2.1.9 There is sufficient medical staffing to provide a suitable after-hours medical roster.

Nursing staff

2.1.10 The nursing team must be led by a full-time nurse with relevant training, expertise and qualification in rehabilitation. This nurse will be the

manager of the unit (supernumerary to direct care provision) and will lead the nursing and operational aspects of the unit.

2.1.11 Nursing staff numbers are to be sufficient to ensure the safe and effective nursing management of patients within the service. The majority of nursing staff will hold qualifications/experience in rehabilitation. Each service must demonstrate its professional nursing specialisation compliance with the appropriate nursing standard or framework.
Note: For further details about nursing standards and competencies please refer to the Australasian Rehabilitation Nurses' Association (ARNA).

2.1.12 Nursing staff within a rehabilitation medicine service also have responsibility for participation in the rehabilitation needs of patients to facilitate patient recovery and independence. There shall be sufficient nursing care hours (over a 24-hour period) for nursing staff to deliver, facilitate and reinforce therapy programs. This is especially important after business hours and on weekends and public holidays.

2.1.13 Nursing staffing hours should be sufficient to ensure full participation in all interdisciplinary team processes including case conferences, team meetings, goal planning meetings and family meetings as well as in patient and staff education and teaching activities.

2.1.14 All nursing care, over the entire 24-hour period, must be under the supervision of a registered nurse.

2.1.15 The service shall employ nursing experts according to the rehabilitation casemix (such as Continence, Wound, Pain, Stomal nurses). The nursing service must have an active practice development plan which clearly reflects the education and learning needs of rehabilitation nurses.

2.1.16 There should be a preponderance of registered nurses over enrolled nurses and assistants in nursing.

2.1.17 Nursing hours may need to increase if the rehabilitation medicine service caters for patients with acute medical issues and /or high nursing dependency.

2.1.18 It is recognised that individual rehabilitation medicine services may have their own methodology for determining nursing numbers (for example, load ratios). However, where that is not the case the following can be used as a guide to nursing staffing levels for a rehabilitation medicine service: For each 10 inpatient beds, there should be a minimum of 11.75 FTE nursing staff. This number may rise to 14.75 FTE for services which require greater nursing intensity, such as spinal cord injury rehabilitation. These figures include the Nurse Unit Manager, but do not include the Clinical Nurse Consultant or the Nurse Educator which are recommended at ratio of 0.5 FTE for each 10 inpatient beds.

Allied Health and Other Professional Staff

Table 1 Allied Health Staff to Patient Ratios for each 10 Inpatients

Impairment Type	Occupational Therapist	Physio-Therapist	Allied Health Assistant	Speech Pathologist	Clinical Psychologist	Neuro- Psychologist	Social Work	Dietitian
Amputation	1	1.5	0.5	consult[1]	0.5	consult[1]	0.6	0.4
Stroke / Neurology	1.5	1.5	0.5	1.5	0.5	0.5	1.0	0.5
Orthopaedic	0.8	1.25	0.5	0.1	0.2	consult[1]	0.5	0.4
Major Trauma[2]	1.2	1.5	0.5	0.2	0.4	0.5	1.0	0.6
Spinal Cord Dysfunction[2]	2	2	0.5	0.25	0.5	0.3	1.2	0.4
Traumatic Brain Injury[2]	1.5	1.5	0.5	1.5	0.8	0.8	1.2	0.5
Reconditioning and Restorative	1.2	1.25	0.5	0.2	0.4	0.2	1.0	0.5

Notes:

a. This table provides indicative of staffing levels for a five day per week rehabilitation program. A six or seven day per week program requires additional staffing. Refer to 2.1.26

b. The staffing levels outlined in this document do not include staffing sufficient to relieve staff who are on leave.

c. The staffing levels do not include time required for teaching and research activities.

d. [1]'consult' denotes the availability of staff on a consultation basis, as required.

e. [2] Major Trauma is defined as complex injuries to multiple body systems that may also include spinal cord dysfunction and/or traumatic brain injury (TBI).

f. Prosthetist / Orthotist: See section 2.1.33 and 2.1.34

2.1.19 Patients admitted to the rehabilitation medicine service will receive an appropriate quantum and mix of therapy to enable them to achieve an optimal rehabilitation outcome within an appropriate timeframe. This will vary according to individual patient factors such as the nature of the patient's impairment, the time since onset of impairment, the presence of co-morbid conditions, the patient's ability to tolerate therapy, their cognition and their motivation to undertake rehabilitation. There is mounting evidence in the literature on the benefits of greater therapy intensity in improving functional outcomes and improving the efficiency of the rehabilitation process[7, 8, 9, 10].

2.1.20 The ultimate determinant of the staffing levels will be the type and intensity of therapy needed by patients in the unit, to meet their requirements. While the staffing ratios outlined in Table 1 are a useful guide to the overall allied health staff establishment required, the aim must be the delivery of appropriate rehabilitative therapy[12].

2.1.21 The appropriate amount of therapy that patients receive will be a minimum of three hours per day for patients who have the capacity to tolerate this amount of therapy. This should occur on a minimum of five days per week.

2.1.22 'Therapy', as used in 2.1.19 (above), generally includes physiotherapy, occupational therapy, and speech and language therapy, delivered by professionally qualified and skilled staff, or by allied health assistants under the supervision of professionally qualified allied health staff. Therapy can be delivered on either an individual or group basis, but if delivered on a group basis the patient must be an active group participant and must be following an individually tailored program. Therapy can also include that delivered by other professional disciplines, such as defined in 2.1.36 or other professionally qualified staff, depending upon patient need.

2.1.23 Table 1 provides guidelines for allied health and allied health assistant staffing of the rehabilitation medicine service at the unit level. However, there may be a high degree of variability between the casemix of different rehabilitation medicine services and this must be considered in determining the allied health levels for different services.

2.1.24 As well as adjusting staffing levels to suit the casemix of the rehabilitation medicine service, the staffing levels for allied health and allied health assistants must also be adjusted to account for the percentage of time that these staff have available for the delivery of direct patient care. In essence, only a percentage of the time that a therapist has available to them is 'patient attributable' time. Only a percentage of 'patient attributable' time is available for direct patient care, because 'patient attributable' time also includes other patient-related activities such as attending case and family conferences and ward rounds, writing reports and travel.

2.1.25 In cases where allied health staff are to be available on a consultation basis, the consultation should occur in a timely manner so as to not interfere with the rehabilitation program or prolong the inpatient rehabilitation episode.

2.1.26 Staffing numbers might need to be adjusted if the Rehabilitation Medicine service caters for patients with special

needs (for example, bariatric patients, or patients with infection control requirements), as the time taken for staff to deliver effective therapy programs in these circumstances is greater. Specialist rehabilitation medicine services are likely to require a higher level of allied health staffing including those that manage a complex caseload e.g. people with dual diagnoses, challenging behaviour, substance misuse and dementia.

2.1.27 The provision of therapy on weekends is strongly recommended as it has been shown to increase functional independence, physical activity, quality of life and in some cases, reduce length of stay[13, 14].

2.1.28 There should be sufficient staff to meet the psychosocial needs of patients.

2.1.29 There should be sufficient staff to allow relevant rehabilitation team members to participate in case and family conferences and ward rounds, when required.

2.1.30 The services of a neuropsychologist are essential in services where patients with brain impairment are managed.

2.1.31 Clinical psychologists are employed in all units where patients with complex behavioural issues are treated and where adjustment to the disability may be an issue.

2.1.32 Brain impairment and spinal cord dysfunction programs have access to an outreach team comprising appropriate medical, nursing and allied health staff.

2.1.33 Amputee rehabilitation programs have close liaison with prosthetists who are able to provide a comprehensive prosthetic service and who attend assessments when prostheses are prescribed.

2.1.34 Close liaison with an orthotist is required for stroke and neurological patients, major trauma patients, and those with spinal cord dysfunction and traumatic brain injury. If prosthetists / orthotists are not part of the employed staff establishment, then arrangements with a private provider are to be made.

2.1.35 The majority of patients in a rehabilitation medicine service will require input from pharmacists. The pharmacist should be an integral part of the rehabilitation team.

2.1.36 Nominated staff from other disciplines such as exercise physiology, podiatry, diversional therapy, music therapy, leisure therapist / recreation officer or therapist, rehabilitation counselling, sexual therapy, rehabilitation engineering and vocational rehabilitation should be available as required.

2.1.37 Access to health care interpreters must be available to allow optimal comprehension of rehabilitation, goals and overall process.

2.1.38 Cultural support services, culturally appropriate goals and acknowledgement of cultural norms for certain patients where appropriate, should be in place.

Support Staff

2.1.39 Each rehabilitation medicine service should have available adequate numbers of support staff to ensure the effective running of the service.

2.1.40 Administrative support is required to ensure that rehabilitation outcomes data are collected and entered onto an appropriate database and submitted to the relevant health authority and to AROC.

2.1.41 Staff to assist in the movement of patients to therapy areas should be available if required so that therapy programs can be scheduled without interruption and without using treatment time of allied health and nursing personnel.

2.1.42 There should be adequate cleaning staff to meet the needs of the service and to cater for patients with infection control issues.

Other comments regarding staffing

2.1.43 Nursing staff levels should be adequate to ensure that the rehabilitation medicine service is able to provide appropriate rehabilitation support outside of usual business hours, to allow patients to progress with their rehabilitation program during these times.

2.1.44 The use of family and appropriately trained volunteers in rehabilitation programs should be encouraged and supported.

2.1.45 The use of formal peer support services or involvement of people with similar disability should be encouraged in rehabilitation services when appropriate.

2.1.46 Staffing levels for the rehabilitation medicine service must reflect the needs of the service to safely manage acute medical and surgical issues as they arise without disrupting the care of other patients.

2.2 Human resource management

2.2.1 The service is directed by a rehabilitation medicine physician.

2.2.2 The Director of the Rehabilitation Medicine Service (rehabilitation medicine physician) is responsible for the co-ordination of treatment and the monitoring of standards of treatment.

2.2.3 Each inpatient rehabilitation service will have appointed a Nurse Unit Manager. The Nurse Unit Manager will be responsible for professional services and operational requirements of the service related to nursing.

2.2.4 There is documented evidence of a line of responsibility from the person in charge of the service to a senior administrator.

2.2.5 The senior clinician of each discipline is responsible to the Director of the Rehabilitation Medicine Service for the standard of clinical service provided by all practitioners in that discipline.

2.2.6 Each allied health professional staff member is responsible for the quality of care given to individual patients under the overall care of the assigned rehabilitation medicine physician.

2.2.7 In each clinical unit there is at least one senior therapist assigned permanently. Junior staff in the same discipline may be rotated to facilitate their professional development. However, if this occurs, due consideration must be given to the impact on clinical services in that

discipline and on the service as a whole.

2.2.8 The nursing staff is sufficient in number and have appropriate experience to fully perform the nursing duties necessary for the proper care of patients and safety of staff at all times. Nursing requirements vary according to the nature of the disability and reflect the recorded dependency scale of the patients.

2.2.9 All staff are adequately skilled, qualified and knowledgeable about rehabilitation in order to perform their duties professionally and effectively.

2.2.10 The rehabilitation medicine service and the relevant hospital administration recognise the need for staff to maintain and develop their skills and knowledge. In order to provide staff capacity to do so there must be provisions within industrial awards as well as through funding support for continuing professional development.

2.2.11 Within the organisation there is a current list of all professional staff including their qualifications, experience and duties. This list is updated annually and includes evidence of registration with the appropriate Board or agency with evidence that qualifications have been verified and compliance with continuing professional development requirements are confirmed.

2.2.12 There is a position description for each category of professional position.

2.2.13 Specialised procedures are undertaken only by staff with appropriate qualifications and experience. An appropriate credentialing process and quality monitoring is established.

2.2.14 Where the service's staffing complement does not contain a full range of the professional expertise required, there are documented arrangements for referral to outsourced professionals to provide the required expertise.

2.2.15 Annual staff appraisal is conducted with appropriate documentation. These are performed by each staff member's discipline specific supervisor and overseen by the Director.

2.2.16 There is a documented management review process, which regularly reviews and adjusts the overall staffing needs of the organisation.

3. Facilities and equipment

The facilities and equipment are both adequate and appropriate for the rehabilitation needs of patients and are also able to provide a safe learning environment for retraining in lost skills.

3.1 Facilities

3.1.1 The rehabilitation medicine service conforms to the relevant universal design and construction standards for Australia and New Zealand.

3.1.2 There is wheelchair access to all areas – wards, therapy areas, dining rooms, toilets and outside areas.

3.1.3 Unless otherwise approved, a rehabilitation medicine service provides rails and hand holds in all

corridors, ramps, stairs, bathrooms and toilets to ensure safe movement of people with disabilities.

3.1.4 There is ready access in the facility to all mobility equipment such as wheelchairs and walking frames to allow free access to all patients, their families and their visitors.

3.1.5 There is a safe environment for patients with cognitive impairment.

3.1.6 In inpatient facilities there is a designated dining room area for patients.

3.1.7 There is a designated day room for the use of patients, their families and their visitors when they are not involved in therapy.

3.1.8 There are private or quiet spaces for the use of patients, their families and their visitors when they are not involved in therapy.

3.1.9 There is a meeting room suitable for case conferences and family meetings.

3.1.10 There is a physiotherapy treatment area with adequate open space where gait training, general exercises, gymnastics and recreational activities may be performed. Ideally there should also be an outdoor wheelchair / gait retraining area.

3.1.11 There is an occupational therapy treatment area including space for group activities. There should also be facilities to allow for kitchen and laundry training.

***Note**: Various designated spaces for these therapy areas may be combined as long as they do not interfere with patient treatment from the view of either of these two disciplines.

3.1.12 There are rooms for individual therapy, counselling and consultations.

3.1.13 There is access to a room suitable for the application and removal of plasters (or similar) or bandages and for the manufacture of simple orthotics.

3.1.14 There is a heated hydrotherapy pool (ideally on-site) with access for people with disability.

3.1.15 There are appropriate storage areas for equipment which includes access to the power supply.

3.1.16 Wi-Fi or other internet access should be available for patients (preferably at no cost to the patient).

3.1.17 Appropriate and accessible nurse call systems / other environmental control systems are available in bed and therapy spaces and common areas.

3.2 Equipment

3.2.1 Based on the needs of the patient casemix, a rehabilitation medicine service provides appropriate equipment and assistive technology.

Where the service does not have all the necessary pieces of equipment available on site, there are documented arrangements for referral to other facilities or organisations that are able to provide them.

3.2.2 A rehabilitation medicine service provides information regarding hospital and community-based services, insurance and disability support schemes (e.g. National Disability Insurance Scheme, ACC in NZ) to enable people with disabilities

to make informed choices regarding services and equipment necessary to meet their ongoing needs.

4. Policies and procedures

There is documentation of policies and procedures to ensure safe, appropriate, accountable, effective and measurable improvement in the patients involved in rehabilitation programs following illness or injury.

4.1 Patient related care

4.1.2 There are clear written criteria for admission to the Rehabilitation Medicine service. These criteria are made available to referrers.

4.1.3 The rehabilitation medicine service provides consultation and triage to determine appropriateness for admission into the inpatient rehabilitation program and/or advice on alternative care.

4.1.4 There is a clearly defined assessment procedure for each patient admitted to the hospital for rehabilitation.

4.1.5 There is a written rehabilitation plan for each patient based on the assessment. The plan is to be patient centred and states the person's needs and limitations as well as the goals. The plan is prepared by a multidisciplinary team with the active participation of the patient and family and includes provision for continuing care, review and discharge.

4.1.6 The progress of the patient is evaluated regularly against the established plan with standard measures of function. Documentation of progress forms part of the medical records.

4.1.7 There is a formal planned discharge procedure including provision of a written medical and / or multi-disciplinary discharge summary which should be provided to the patient, the general practitioner and other relevant services. Other direct communication and collaboration with the general practitioner should be undertaken as necessary.

4.1.8 There is documented evidence of weekly case management meetings at which individual program plans are reviewed. These meetings involve the rehabilitation medicine physician and appropriate nursing and allied health professionals.

4.1.9 All patients are offered follow-up care and review as often as it is considered necessary and practical.

4.1.10 Where relevant, there are established links to in-reach, outpatient, day rehabilitation and community rehabilitation services.

4.1.11 Ideally, inpatient services will offer multidisciplinary ambulatory rehabilitation programs post discharge (e.g. early supported discharge, transitional rehabilitation, telehealth, and outreach) to provide continuity of care and community reintegration[15].

4.1.12 There are documented policies for liaison and collaboration with general practitioners, primary care and other

healthcare providers to ensure continuity and integration of care[15].

4.1.13 There are processes to ensure that patients who are capable of returning to work are provided with the best opportunity to do so with direction to appropriate vocational rehabilitation services.

4.1.14 There is a documented policy and evidence of ongoing consultation and communication with referring and treating healthcare practitioners.

4.1.15 There are documented policies for all procedures within the facility with evidence that these are updated regularly.

4.1.16 There are documented policies and effective procedures for the management of patients who might become unwell during the rehabilitation episode and who require acute care assessment, management and/or transfer.

4.2 Management of patient records

4.2.1 There are secure storage and retrieval systems for patient records.

4.2.2 Confidentiality of records is maintained.

4.2.3 Records are retained and accessible for the statutory required periods.

5. Quality improvement and risk management activities

The service has a quality improvement and risk management framework with appropriate single discipline and multidisciplinary activities and projects addressing consumer involvement, access, and appropriateness, effectiveness, safety and efficiency of treatment programmes. The service submits data to the Australasian Rehabilitation Outcomes Centre (AROC) and regularly reviews its performance against benchmarks established by AROC.

5.1 Procedures exist to ensure evaluation of the quality of services provided. Quality management follows a recognised process and is undertaken by an established hospital accreditation organisation recognised in Australia or New Zealand.

5.2 Evaluation of outcomes remains a major strength of rehabilitation medicine services. This is achieved by monitoring selected procedures, collecting data and assessing information, feeding back to the staff, taking action and reviewing results. These steps form the continuous quality management process. The service should record rehabilitation outcome data on all patients and contribute to AROC data collection.

5.3 The service should regularly document the ACHS Rehabilitation Medicine Clinical Indicators[16].

5.4 Feedback is actively and regularly sought from patients, families, carers, staff, suppliers and the users of any service provided by the facility.

5.5 The service actively promotes the principles of evidence based clinical practice for all professional staff employed within the service.

6. Education and Teaching

The service is actively engaged in continuing education, teaching and continuing professional development.

6.1 There is a documented policy and appropriate support for the continuing education of medical, nursing and allied health professional staff.

6.2 A minimum of 3% of effective full-time hours is allocated for formal in-service staff training and development at no cost to the staff.

6.3 The service participates in under-graduate and postgraduate medical, nursing and allied health service teaching programs.

6.4 The service promotes and provides opportunities for all staff to undertake continuing professional development at both discipline-specific and multi-disciplinary (e.g. multi-disciplinary in-service) levels.

7. Research

The service promotes the importance of and is actively engaged in research activity.

7.1 The service actively promotes the importance of research amongst its professional staff and promotes a culture which is supportive of staff being engaged in research.

7.2 The service ensures that Rehabilitation Medicine trainees working within the service are supported to undertake research activities particularly those required as part of the training program (e.g. research module).

7.3 The staffing levels outlined in section 2 of these Standards (Staffing) do not include time required for research activities.

Appendix

References

1. AFRM Standards for the provision of Paediatric Rehabilitation Medicine Inpatient Services in Public and Private Hospitals 2015
2. Standards for the provision of Rehabilitation Medicine Services in the Ambulatory Setting 2014
3. Rehabilitation Medicine: Advanced Training Curriculum. 1st ed; RACP (2010)
4. The Role of the Rehabilitation Physician (2008)
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