



The Royal Australasian
College of Physicians



Australasian Faculty of
Rehabilitation Medicine

STANDARDS

FOR THE PROVISION OF
REHABILITATION MEDICINE SERVICES

in the

AMBULATORY SETTING

2014

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INTRODUCTION

The *International Classification of Functioning, Disability and Health*¹ (ICF) defines disability as an umbrella term for impairments, activity limitations, and participation restrictions. Disability refers to the negative aspects of the interaction between individuals with a health condition (such as cerebral palsy, stroke, and depression) and personal and environmental factors (such as negative attitudes, inaccessible transportation and public buildings, and limited social support).

In Australia, results from the *Survey of Disability, 2012*² indicated that 4.2 million people nationally (18.5 per cent of the population) have a disability. The prevalence of disability increases greatly at older ages but is an important issue for people of all ages, including children.

For about 30 per cent of these people with a disability, significant assistance or support is required in the core activity limitations of communication, mobility and/or personal care.

For 22 per cent of people with a disability, the disability 'just came on', for 15 per cent it was acquired following an accident or injury, for 14 per cent it was related to disease or illness and for 1.5 per cent it followed a medical or medical procedure³. For older people, disability is often progressive and related to multiple chronic diseases.

In the years ahead, disability will be an even greater concern because its prevalence is on the rise. This is due to ageing populations and the higher risk of disability in older people as well as the increase in chronic health conditions such as diabetes, cardiovascular disease, cancer and mental health disorders.

Disability is associated with loss of independence and reduced quality of life. People with disability may need access to support services. People with severe disability may need to move to residential facilities. The use of support services, particularly residential care facilities, is costly for the person with disability and society generally as the government provides subsidies for access to support services and residential care.

Rehabilitation aims to minimise and prevent disability as well as help people with disabilities improve their participation in life despite their impairment and reduce the overall burden of care for their families and society.

In keeping up with wider medical and technological advancement in the provision of healthcare, it is recognised that health services provided outside the hospital are important and require further development. Indeed, there is now an international agreement in the United Nations (UN) Convention on the Rights of Persons with Disabilities⁴, to which Australia is a signatory, that governments will provide and increase services for habilitation (Article 25) and rehabilitation (Article 26) for people with disabilities.

In order to achieve full participation and improved quality of life for this population, it is imperative that appropriate policies and programs, including rehabilitation delivered in the ambulatory setting, be developed.

Purpose & Intent

The ageing of the populations in Australia and New Zealand and the rising cost of expensive hospital care are placing tremendous pressure on governments. What is needed is greater reliance on ambulatory models of care, both in disease management and also in the provision of rehabilitation after people have suffered sudden or progressive onset of disabling conditions as a result of illness, injury or the effects of chronic disease. Not only are ambulatory models of care likely in many cases to be more cost effective than hospital-based care, they are often more convenient and contextually appropriate for the person receiving care. Yet, the development of ambulatory rehabilitation models, and funding for ambulatory services, has lagged behind the development of other service models. While it is not the intention of this document to explore the reasons for the paucity of funded ambulatory rehabilitation programs, it is the intention of the Australasian Faculty of Rehabilitation Medicine (AFRM) of The Royal Australasian College of Physicians (RACP) to take a proactive approach by developing these standards.

While the RACP's 2005 Standards for Rehabilitation Medicine⁵, included a section on ambulatory rehabilitation, these standards are the first stand alone and comprehensive guide to ambulatory rehabilitation. However, they are a first iteration only and will require ongoing development and refinement over subsequent years.

This document seeks to be inclusive of the range of ambulatory rehabilitation services provided under the various models of ambulatory care across the states and territories of Australia and New Zealand, and the different sectors of the health care system. This document is not intended for formal accreditation or audit purposes; its objectives are to document consensus standards regarding organising, providing and monitoring the provision of ambulatory rehabilitation practices.

The purpose of these standards is to guide RACP Fellows, governments, health service planners and administrators in their decision making about the provision of rehabilitation medicine services in the ambulatory setting. This document builds upon previous versions of the AFRM Standards documents and incorporates updated best practice guidelines into one single document, which can be used as a reference. Many of the standards are expressed as consensus guidelines of good rehabilitation practice and are thus not intended for use in a formal accreditation audit process.

Methodology

This document was produced by a Working Group of AFRM Fellows which was formed in June 2012. These Standards are the result of consensus reached within this Working Group of experts. In addition, this document was also informed by a review of the literature and consultation with relevant external stakeholders as detailed in the Acknowledgement section at the end of this document.

Application of these Standards to ambulatory rehabilitation programs

AFRM is committed to the provision of comprehensive, high quality care in the services in which its Fellows practice. This document 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. Nor do the standards 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 Service⁶.

These Standards relate to the provision of rehabilitation programs that are non-inpatient programs only and are to be considered general standards.

Future development of the AFRM Standards

Over time, it is the intention of the AFRM to develop Standards for use across a range of settings and programs as newer service models mature. Further detail on the rehabilitation needs of special patient populations (for example, patients with multi-resistant organisms and bariatric patients) will also be developed in subsequent revisions of these standards.

ASPECTS OF SERVICE PROVISION COVERED BY THESE STANDARDS

1. GOVERNANCE

A specialist rehabilitation medicine service under the direction of a rehabilitation physician (Fellow of the AFRM or equivalent) provides comprehensive, patient-centred multidisciplinary 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^{7,8}.

2. STAFFING

There is a full 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 attending the ambulatory rehabilitation 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 safe, adequate and appropriate for the rehabilitation needs of patients. Facilities should support families and care givers to remain in attendance and be involved in the patient's rehabilitation program. Rehabilitation is also provided in patients' homes and the community. If the rehabilitation is provided in patients' homes, then the safety of the attending clinicians must be considered.

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.

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, appropriateness, effectiveness, safety and efficiency. The service will submit data to the Australasian Rehabilitation Outcomes Centre (AROC) and will regularly review its performance against benchmarks established by AROC⁹.

6. EDUCATION AND RESEARCH

The service is actively engaged in continuing education and teaching and actively promotes the importance of research.

DEMONSTRATING THE STANDARDS

1. GOVERNANCE

A specialist rehabilitation medicine service under the direction of a rehabilitation physician (Fellow of the AFRM or equivalent) provides comprehensive, patient-centred multidisciplinary 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.

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| <p>1.1 Definitions of rehabilitation medicine and medical rehabilitation are acknowledged and utilised to identify a rehabilitation medicine unit.</p> <p>1.2 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.</p> <p>1.3 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.</p> <p>1.4 Medical rehabilitation in its broadest sense is part of all patient care. It is the function of every practising doctor and involves the prevention, assessment, management and medical supervision of a person with disability until that person has attained an adequate and appropriate level of performance.</p> <p>1.5 Rehabilitation medicine services are identified units of patient care providing comprehensive rehabilitation services for inpatients and non-inpatients as well as in the community, with each patient's clinical management being under the supervision of a rehabilitation physician. The ambulatory rehabilitation service provides an organised system of care in an ambulatory setting, such as in a facility (including outpatient clinics, day hospitals or community centres) or in a residential setting (including residential care facilities, or domestic or community settings).</p> <p>1.6 A rehabilitation medicine service aims to assist people with loss of function or ability due to injury or disease 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, treatment, regular review, discharge planning, community integration and follow-up of people referred to that service.</p> | <p>1.7 The designated rehabilitation medicine unit is directed by a rehabilitation physician and each patient's clinical management is under the supervision of a rehabilitation physician.</p> <p>1.8 The main difference in carrying out the role of rehabilitation physicians in the ambulatory setting compared with inpatient rehabilitation is that the physician may have less direct interaction with the patient and a greater advisory and consultative role.</p> <p>1.9 Rehabilitation physicians work collaboratively with general practitioners who are responsible for the primary medical care of the patient, and other health professionals in the community setting. Effective, efficient and timely communication between the ambulatory rehabilitation service, the general practitioner, relevant hospital departments and community-based specialists is mandatory to prevent sub-optimal outcomes.</p> <p>1.10 The rehabilitation physician has a pivotal role to play in the communication of disability-related issues between the health system and the social care system through the provision of reports, certifications and assessments.</p> <p>1.11 Ambulatory rehabilitation assists people with functional limitations to achieve goals that will lead to reduced activity limitations, greater community participation and improved quality of life.</p> <p>1.12 The intent of some ambulatory rehabilitation services is to act as a type of Hospital in the Home service where the aim is to prevent the need for inpatient care (acute or subacute) or reduce the duration of this care. It can constitute a continuation of an inpatient episode of rehabilitation, or be a new episode of rehabilitation commencing after hospitalisation. This type of program may also support timely discharge from the hospitals (both from acute care and rehabilitation facilities).</p> <p>1.13 The delivery of ambulatory rehabilitation services can also include consultative services, particularly to outer metropolitan, rural, regional and remote areas. Modalities that can be utilised to deliver this important service can include visiting clinics (e.g. fly-in or drive-in) or virtual access (e.g. telephone</p> |
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consultation, formal email consultation and telehealth consultations via videoconference).

- 1.14 In addition, outpatient services may include outreach and telehealth programs where multidisciplinary teams provide consultation and support to patients and treating therapists in areas without local specialist rehabilitation services.
- 1.15 While the majority of ambulatory rehabilitation will be provided by general rehabilitation services, specialty ambulatory rehabilitation programs are appropriate in a number of situations such as spinal cord injury or traumatic brain injury.
- 1.16 Specialty streams of ambulatory rehabilitation, as with inpatient programs, provide a critical mass for the development of expertise among clinicians and facilitate the delivery of best practice and evidence-based care. Specialty streams of ambulatory rehabilitation should be established when there is clear evidence that they can provide effective evidence-based programs. This will be feasible in metropolitan health networks and large rural cities while in smaller rural and remote areas this may not be possible. A hub-and-spoke approach can be utilised to maximize the regional outreach of specialty ambulatory rehabilitation. Specialty streams of ambulatory rehabilitation may provide case coordination and case management services.

- 1.17 The patient and the rehabilitation team work collaboratively to establish and continuously evaluate short, medium and long-term goals aimed at alleviating restrictions on activity and participation.
- 1.18 A specialist rehabilitation medicine service should be able to demonstrate evidence of planned, coordinated care.
- 1.19 There is a measurement of functional status on admission to and at discharge from the programs in the service. Functional status might also be formally assessed at intervals during the outpatient episode.
- 1.20 The designated rehabilitation unit is accredited with the national safety and quality accreditation scheme of the National Safety and Quality Health Service Standards of the Australian Commission on Safety and Quality in Health Care¹⁰.
- 1.21 The framework for clinical governance in an ambulatory setting is likely to be related to a recognised accreditation system and similar to that applied in a hospital setting.

2. STAFFING

Generally, an ambulatory rehabilitation program is delivered by a core multidisciplinary team with skills and knowledge appropriate to the needs of the patient with the rehabilitation physician playing a central role in the management of the diagnosis and treatment of each patient. 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.

Ambulatory rehabilitation is generally multidisciplinary, but therapies need not necessarily be delivered concurrently. Some patients/clients with complex impairments and activity limitations may be appropriate for single therapist programs on occasions.

Staffing of the Rehabilitation Medicine Service

- 2.1 An ambulatory rehabilitation medicine service should include an adequate number of suitably trained professional and support staff to allow the service to provide appropriate multidisciplinary rehabilitation care in a safe, effective and efficient manner.

- 2.4 Where feasible, the medical staffing includes rehabilitation medicine trainees in the treatment of ambulatory clients and as members of the multidisciplinary team.

Medical Staff

- 2.2 The rehabilitation physician has a central role in the diagnosis and treatment of patients. The rehabilitation physician assists in defining the range of disciplines involved as well as the intensity and duration of ambulatory rehabilitation programs.
- 2.3 Rehabilitation physicians also have an educative role for patients, carers and other clinicians.

Nursing Staff

- 2.5 Nurses with expertise in rehabilitation medicine play an integral role in the multidisciplinary ambulatory rehabilitation team. The role of nursing staff within the ambulatory team is varied and diverse, ranging from undertaking case management to performing advanced clinical duties and procedures (e.g.: stoma care, intrathecal baclofen pump management).
- 2.6 The role of nursing staff in the ambulatory rehabilitation team will vary depending on the patient's treatment needs. Nursing staff may also undertake direct case management and rehabilitation care planning.

Allied Health Staff

- 2.7 Treatment delivered as part of an ambulatory rehabilitation program will include services provided by allied health professionals. Depending on the nature of the patient's impairments and rehabilitation goals, allied health disciplines involved may include physiotherapy, occupational therapy, speech pathology, psychology, neuropsychology, social work, dietetics, exercise physiology, prosthetics and orthotics.
- 2.8 Therapy may also be delivered by allied health assistants under the supervision of allied health professionals.
- 2.9 Allied Health staff may also undertake direct case management and rehabilitation care planning responsibilities as all or part of their position when working in specialised rehabilitation.

Additional and Support Staff

- 2.10 Each ambulatory rehabilitation medicine service should have adequate numbers of support staff available to ensure the service operates effectively.

- 2.11 Administrative support is required to ensure that data on rehabilitation outcomes is collected and entered onto an appropriate database for quality assurance and bench-marking purposes.
- 2.12 The service should have adequate numbers of cleaning staff to meet the needs of the service and to cater for patients with infection control issues.
- 2.13 Services which cater for children and young people of school age will require access to teachers and educational staff including specialist educators.

Factors influencing staffing arrangements

- 2.14 The disciplines and staffing numbers required for the ambulatory rehabilitation service will vary depending on the type(s) of impairment managed by the service.
- 2.15 The table below shows the key disciplines that should be involved in treating different types of impairment as well as an indication of the relative time associated with each discipline.

	Rehabilitation physician	Nurse	Physiotherapist	Occupational therapist	Speech language therapist	Social worker ¹¹	Clinical psychologist / Neuropsychologist	Dietician	Prosthetist / Orthotist	Exercise physiologist	Recreational / Diversional therapist	Allied health assistant
Neurological (includes stroke, acquired brain injury)	++	+	+++	+++	+++	+++	+++	+	+	+	++	++
Spinal (includes spinal cord injury and diseases)	++	++	+++	+++	+	++	+	+	++	+	++	++
Amputee (includes congenital limb deficiency)	+	++	+++	+++		++	+	+	+++	+		++
Orthopaedic (following orthopaedic injury or elective surgery)	+	+	+++	+++		+		+	+	++		++
Reconditioning (generally older people with reduced functioning following a variety of health conditions)	+	++	+++	+++		++	+	+		++	+	++

- + = Low relative time associated to the discipline
 ++ = Medium relative time associated to the discipline
 +++ = High relative time associated to the discipline
 No + = No relative time associated to the discipline

- 2.16 Other factors to be considered in determining the type and number of staffing required in ambulatory rehabilitation include:
- Age of the patient population
 - Geography and location/distance from the rehabilitation facility
 - Acuity/functional level of the patient at the commencement of a rehabilitation program
 - Presence of comorbidities
 - The model of care in place, for example trans-disciplinary and interdisciplinary models allow goals to be addressed by a number of disciplines, involvement of allied health assistants, and group therapy
 - Availability of staff outside the “core” multidisciplinary team when required
 - Direct patient attributable time
 - Indirect patient attributable time (such as case management, phone calls, planning meetings, report writing and travel) and non-clinical time (such as professional development activities, teaching, quality activities)
 - Additional issues associated with people with Non English Speaking Background (NESB) and Aboriginal and Torres Strait Islander, Māori and Pacific Islander people.

3. FACILITIES AND EQUIPMENT

The facilities and equipment are both adequate and appropriate for the rehabilitation needs of patients and provide a safe learning environment for retraining in lost skills. Ambulatory rehabilitation services have differing infrastructure requirements to inpatient rehabilitation services.

Facilities

The rehabilitation medicine service conforms to the relevant Australian or New Zealand standards proclaimed by government and unless otherwise approved, to the requirements for design and construction detailed in the Licensing Standards of the local authorities.

- 3.1 There is wheelchair access to all areas – wards, therapy areas, dining rooms, toilets and outside areas.
- 3.2 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.
- 3.3 There is ready access in the facility to mobility equipment such as wheelchairs and walking frames to allow free access to all patients and their relatives.
- 3.4 There is a safe environment for patients with cognitive impairment.
- 3.5 There is a meeting room suitable for case conferences.
- 3.6 There is a physiotherapy treatment area¹² with adequate open space where gait training, general exercises, gymnastics and recreational activities may be performed. Ideally there should be an outdoor wheelchair/gait retraining area.
- 3.7 There are rooms for individual therapy and consultations.
- 3.8 There is access to a room for the application and removal of plasters (or similar) bandages. This room can also be used for fabrication of upper limb splints, orthoses and prostheses.

- 3.9 Access to a heated hydrotherapy pool (ideally on-site) for people with disability is highly desirable.
- 3.10 There is access to a kitchen area where meal preparation activities can occur.
- 3.11 There is access to a ‘home style’ bathroom where transfer in and out of the bath and shower can be assessed and practiced with varying aids.
- 3.12 Appropriate storage areas for equipment are provided.
- 3.13 Access to independent living facilities for training e.g. access to a kitchen for meal preparation (this could be the same facility for patient training and ordinary staff use), access to shops, bill paying, etc is desirable in some circumstances.
- 3.14 There is access to transport for staff to provide contextual rehabilitation at the person’s home and in their local community.
- 3.15 Where young people of school age are treated, there is access to school facilities.

Equipment

- 3.16 Based on the needs of the patient casemix, a rehabilitation medicine service provides:
- Physical therapy equipment
 - Gait training facilities
 - Functional electrical stimulation equipment for patients with neurological impairment
 - Ultrasound bladder scanner
 - Equipment for aerobic fitness training
 - Equipment for training activities of daily living
 - Equipment for recreation, including toys and

- games when children and young people are treated
- Equipment to provide vocational retraining
- Equipment to support complex communication needs (e.g. augmentative and alternative communication systems)
- Videoconferencing equipment for telehealth consultations
- Equipment for fabrication of upper limb splints, orthoses and prostheses

- 3.17 Where the service does not have all the equipment available on site, there are documented arrangements for referral to facilities able to provide them.
- 3.18 A rehabilitation medicine service provides information regarding community-based services to enable people with disabilities to make informed choices regarding services and equipment necessary to meet their ongoing needs.

Information Technology

- 3.19 Ambulatory rehabilitation services require continuous access to adequate information technology.
- 3.20 The ambulatory rehabilitation services should have secure storage and retrieval systems for patient records.
- 3.21 Confidentiality of records is maintained.

- 3.22 Records are retained and accessible for the statutory required periods.
- 3.23 A register of patients is maintained in a clearly defined order.
- 3.24 There is facilitated access to telehealth technology for home/different facility based therapy and rehabilitation coordination, as well as engagement of client, family and local provider.

Transport

- 3.25 Ambulatory rehabilitation services require access to suitable transportation arrangements and an adequate budget to provide for these arrangements.
- 3.26 The nature of the transportation required will depend on the setting in which the rehabilitation services are provided. For services delivered in a facility, such as an outpatient clinic, program participants may require transportation to the centre. For services delivered in a domestic, residential or community setting, transportation of the allied health professional, nurse or physician will be necessary. In both instances, the mode of transportation must be effective, efficient, and within reasonable timeframe so that the travelling time is practical and reasonably reliable.
- 3.27 The ambulatory rehabilitation services should be self-sufficient and be equipped to provide adequate transportation.

4. POLICIES AND PROCEDURES

The facilities and equipment are both adequate and appropriate for the rehabilitation needs of patients and provide a safe learning environment for retraining in lost skills. Ambulatory rehabilitation services have differing infrastructure requirements to inpatient rehabilitation services.

Patient related care

- 4.1 There are clear written criteria for admission to the rehabilitation medicine service. These criteria are made available to referring providers.
- 4.2 There is a clearly defined assessment procedure for each patient admitted to the service for rehabilitation.
- 4.3 There is a written rehabilitation plan for each patient based on this assessment. The rehabilitation plan needs to be patient-centred and state the person's needs and limitations as well as the goals of the plan. 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.
- 4.4 The progress of the patient is evaluated regularly against the established plan, and with standard measures of function. Documentation of progress forms part of the medical records.
- 4.5 There are documented policies for liaison with community-based services to ensure continuity and coordination of care.
- 4.6 There are processes to ensure that patients who are capable of returning to work are provided with the best opportunity to do so.
- 4.7 There is documented policy and evidence of ongoing consultation and communication with referring and treating healthcare practitioners.

5. QUALITY IMPROVEMENT AND RISK MANAGEMENT ACTIVITIES

- 5.1 The service has a quality improvement and risk management framework with appropriate single discipline and multidisciplinary activities and projects addressing consumer involvement, access, appropriateness, effectiveness, safety and efficiency as well as staff risk and work health and safety issues. The service submits data to AROC¹³ and regularly reviews its performance against benchmarks established by AROC.
- 5.2 Procedures exist to ensure evaluation of the quality of services provided. Quality management follows a process such as the national safety and quality accreditation scheme of the National Safety and Quality Health Service Standards of the Australian Commission on Safety and Quality in Health Care.
- 5.3 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, for adult patients, contribute to the national database held and managed by AROC.
- 5.4 The service should regularly document the AFRM Rehabilitation Medicine Clinical Indicators¹⁴.
- 5.5 Feedback is actively and regularly sought from customers¹⁵ of the service.
- 5.6 The service actively promotes the principles of evidence-based clinical practice for all professional staff employed within the service.

6. EDUCATION AND RESEARCH

- 6.1 The service is actively engaged in continuing education and teaching and actively promotes the importance of research.
- 6.2 The service participates in undergraduate and postgraduate medical, nursing and allied health service teaching programs.
- 6.3 The service actively promotes the importance of research amongst its professional staff, and fosters a culture which is supportive of staff being engaged in research.

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9. *Note: In the case of paediatric rehabilitation services, they will submit data to AROC when a paediatric dataset is established.*
10. The Australian Commission on Safety and Quality in Health Care (ACSWHC), *Accreditation and the NSQHS Standards*. Online, available: <http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/> [last accessed on 21/05/2014]
11. *Note: When the patient has a health condition that is subject to a compensation claim additional social work, medical and other allied health input may be needed to address the greater reporting requirements.*
12. *Note: Various designated spaces for these therapy areas may be combined as long as they do not interfere with patient treatment.*
13. *Note: Paediatric rehabilitation services will submit data to AROC when a paediatric dataset is established.*
14. The Australasian Faculty of Rehabilitation Medicine, *ACHS Clinical Indicators*. Online, available: <http://www.racp.edu.au/index.cfm?objectid=02ACA842-D531-8E15-A8B66E31D4A5C8F4> [last accessed on 21/05/2014]
15. *Note: Customers include patients and their family, staff, suppliers and the users of any service provided by the facility.*



The Royal Australasian
College of Physicians

ABOUT THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

The RACP trains, educates and advocates on behalf of more than 14,800 physicians – often referred to as medical specialists – and 6,000 trainees, across Australia and New Zealand. The College represents more than 32 medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

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