



Australasian Faculty of
Rehabilitation Medicine



The Royal Australasian
College of Physicians

STANDARDS

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

2011

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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 service in public and private hospitals. 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.

Application of these Standards to inpatient rehabilitation programs:

The Australasian Faculty of Rehabilitation Medicine (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. 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 Service (refer Rehabilitation Service Categories document, AFRM, 2006).

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.

Application of these Standards to other rehabilitation settings:

Rehabilitation 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 – for example, an integrated stroke unit or mobile rehabilitation team within an acute hospital). These Standards, while not designed specifically for use in these alternate settings, can nonetheless be used as a guide.

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 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.

Standards

These Standards cover the following six aspects of service provision:

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. (Refer to the documents: Rehabilitation Service Categories (2006) and The Role of the Rehabilitation Physician (2008), available on the AFRM website at <http://www.racp.edu.au/page/racp-faculties/australasian-faculty-of-rehabilitation-medicine>).

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

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.

- 1.1 Definitions of rehabilitation medicine and medical rehabilitation are acknowledged and utilised to identify a rehabilitation medicine unit.

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.

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.

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.

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.

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.

- 1.2 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. the progress of the rehabilitation program is measured against those goals.
- 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, and
- 1.5 There is evidence of planned, coordinated care.
- 1.6 There is 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 inpatient episode.
- 1.7 The designated rehabilitation unit is accredited with the Australian Council on Healthcare Standards, or an equivalent body.

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 admitted to the 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.

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.
- Medical staff**
- 2.1.2 Each 10 inpatient beds within the rehabilitation medicine service should have either 0.4 FTE rehabilitation physicians (Amputation, Orthopaedic, Major Trauma, Pain, Reconditioning / Restorative and other impairment groups) or 0.625 rehabilitation physicians (Stroke, Neurology, Traumatic Brain Injury (TBI), Spinal Cord Dysfunction). These staffing levels are inclusive of the requirement for pre-admission assessment of patients for the service and for routine follow-up of patients of the service.
- 2.1.3 Inpatient services will have allocated junior medical staff (Registrars and 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. 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 2.1.4 (below).
- 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 Registrar. 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 Registrars undertake additional duties (for example, active involvement in community rehabilitation services, outpatient programs and assessing patients in acute care, then these duties are not to be included in the calculation of the Registrar hours required to support the inpatient rehabilitation beds.
- 2.1.5 Each rehabilitation medicine service should aim to obtain accreditation as a suitable training setting for registrars undergoing advanced training in rehabilitation medicine.
- 2.1.6 In some situations a Career Medical Officer may replace a RMO or Registrar.
- 2.1.7 In some rare situations the junior medical staff duties may be covered by an additional allocation of rehabilitation physician time.
- 2.1.8 There is sufficient medical staffing to provide a suitable after-hours medical roster.
- Nursing staff**
- 2.1.9 The nursing team must be led by a full-time nurse with relevant specialisation. 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.
- 2.1.10 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 "National Specialisation Framework" (National Nursing and Nursing Education Taskforce, 2006) - where Rehabilitation Nursing is recognised as a National Professional Specialisation.
- Note: For further details about nursing standards and competencies please refer to the Australasian Rehabilitation Nurses Association at <http://www.arna.com.au/index.htm>
- 2.1.11 Nursing staff within a rehabilitation medicine service also have responsibility for delivering nursing therapy in order 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.

- 2.1.12 All nursing care, over the 24 hour period, must be under the supervision of a registered nurse.
- 2.1.13 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.
- 2.1.14 There should be a preponderance of registered nurses over enrolled nurses and assistants in nursing.
- 2.1.15 Nursing hours may need to increase if the rehabilitation medicine service caters for large numbers of patients with high nursing dependency.
- 2.1.16 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 injury rehabilitation. These figures include the Nurse Unit Manager, but do not include the Clinical Nurse Consultant or the Nurse Educator. An additional 0.5 Clinical Nurse Consultant in Rehabilitation and 0.5 Rehabilitation Nurse Educator is required for each 10 inpatient beds.
- 2.1.17 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.
- 2.1.18 The ultimate determinant of the appropriateness of the staff establishment of the rehabilitation medicine service will be the amount and type of therapy and care that patients admitted to the service actually receive. While the staffing ratios outlined in the Table at 2.1.22 (below) are a useful guide to the overall allied health staff establishment required, the ultimate aim must be the delivery of appropriate rehabilitative therapy.
- 2.1.19 The appropriate amount of therapy that patients receive will range from a minimum of three hours for patients who have the capacity to tolerate this amount of therapy, down to lesser amounts, based on patient need and capacity to participate. This should occur on a minimum of five days per week.
- 2.1.20 '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 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.
- 2.1.21 'Therapy', as used in 2.1.19 can also include that delivered by other professional disciplines, such as Exercise Physiologists, Psychologists, or other professionally qualified staff, depending upon patient need.
- 2.1.22 The following table provides guidelines for allied health and allied health assistant staffing of the rehabilitation medicine service at the unit level. It should be noted that staffing levels for individual services will need to take into account the casemix of the service.

Allied Health staff

ALLIED HEALTH STAFF to PATIENT RATIOS for EACH 10 INPATIENTS

Impairment type	Impairment type Occupational	Physio-Therapist	Allied Health Assistant	Speech Pathologist	Clinical Psychologist	Neuro-Psychologist	Podiatry	Dietitian	Social Work	Exercise Physiologist
Amputation	1	1.5	0.5	consult ¹	0.5	consult ¹	0.2	0.4	0.6	0.5
Stroke / Neurology	1.5	1.5	0.5	1.5	0.2	0.6	0.2	0.5	1.0	0.5
Orthopaedic	0.8	1.25	0.5	0.1	0.2	consult ¹	0.2	0.4	0.5	0.2
Major Trauma ²	1.2	1.25	0.5	0.2	0.2	consult ¹	consult ¹	0.4	0.6	0.2
Spinal Cord Dysfunction ²	2	2	0.5	0.25	0.5	0.1	0.2	0.4	1.2	0.5
TBI ²	1.5	1.5	0.2	1.5	0.2	1.0	consult ¹	0.5	1.2	consult ¹
Pain	1	1.25	0.2	consult ¹	0.6	consult ¹	consult ¹	0.4	0.5	0.2
Reconditioning and Restorative	1.2	1.25	0.5	0.2	0.2	0.2	0.2	0.5	1.0	0.5

Notes:

- a. ¹'consult' denotes the availability of staff on a consultation basis, as required.
- b. ² For major trauma that includes spinal cord dysfunction and/or Traumatic Brain Injury (TBI), use either the spinal cord dysfunction or TBI staffing levels.
- c. Prosthetist / Orthotist: See section 2.1.32
- d. Impairment categories are taken from the AROC Impairment codes, AUS Version 1, July 2007.
- e. The staffing levels in the table have been adapted from the 'Guidelines for Allied Health Resources required for the provision of Quality Rehabilitation Services', Version 10, 2007. (Allied Health in Rehabilitation Consultative Committee) and the Standards for Adult Rehabilitation Medicine Services in Public and Private Hospitals (AFRM, 2005).
- 2.1.23 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, and 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.
- 2.1.24 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 unnecessarily interfere with the rehabilitation program or prolong the inpatient rehabilitation episode.
- 2.1.25 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.
- 2.1.26 The provision of therapy on weekends is strongly recommended.
- 2.1.27 There should be sufficient staff to meet the psychosocial needs of patients.
- 2.1.28 There should be sufficient staff to allow relevant rehabilitation team members to participate in case and family conferences and ward rounds, when required.
- 2.1.29 The services of a Neuropsychologist are essential in services where patients with brain impairment are managed.
- 2.1.30 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.
- 2.1.31 Brain impairment and spinal cord dysfunction programs have access to an outreach team comprising appropriate medical and allied health staff.
- 2.1.32 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. 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.
- 2.1.33 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.
- 2.1.34 Nominated staff from other disciplines such as diversional therapy, music therapy, leisure therapist / recreation officer, rehabilitation counselling, sexual therapy and rehabilitation engineering should be available when required.
- 2.1.35 Access to interpreters for optimal comprehension of rehabilitation, goals and overall process. Culturally appropriate goals and acknowledgement of cultural norms for certain patients where appropriate, should be in place.

Support Staff

- 2.1.36 Each rehabilitation medicine service should have available adequate numbers of support staff to ensure the effective running of the service.
- 2.1.37 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.
- 2.1.38 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 taking the time of allied health and nursing personnel.
- 2.1.39 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

- 2.1.40 The staffing levels outlined in this document assume that leave relief is provided.
- 2.1.41 Staffing levels should be adequate to ensure that the rehabilitation medicine service is able to provide an appropriate rehabilitation environment outside of usual business hours, to allow patients to progress with their rehabilitation program during these times.
- 2.1.42 The use of family and volunteers in rehabilitation programs is to be encouraged and supported, but not at the expense of professional and support staff.
- 2.1.43 The use of formal peer support services or involvement of people with similar disability should be encouraged in rehabilitation services when appropriate.
- 2.1.44 Staffing levels for the rehabilitation medicine service must reflect the needs of the service to manage acute medical and surgical issues as they arise.

2.2 Human resource management

- 2.2.1 The service is directed by a rehabilitation physician.
- 2.2.2 The Director of the rehabilitation medicine service 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 nursing professional services and operational requirements of the service.
- 2.2.4 There is documented evidence of a line of responsibility from the person in charge of the service to senior administration.
- 2.2.5 The senior clinician of each discipline is responsible to the Director of the Rehabilitation Service for the standard of clinical service provided by the practitioners in the service.
- 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 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.
- 2.2.8 Nursing requirements vary according to the nature of the disability and reflect the recorded dependency scale of the patients. The nursing staff are sufficient in number and have appropriate experience to fully perform the nursing duties necessary for the proper care of patients at all times.
- 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 and provide them with capacity to do so through the application of provisions within industrial awards as well as through the provision of funding support where possible.
- 2.2.11 There is a current list of professional staff including their qualifications, experience and duties. This list is updated annually, and includes evidence of registration with the appropriate Board or agency where this is pertinent. There is evidence that qualifications have been verified.
- 2.2.12 There is a job description for each category of professional position.
- 2.2.13 Specialised procedures are undertaken only by staff with appropriate qualifications and experience; and 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 other resources.
- 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.

2.3 Continuing education

- 2.3.1 There is a documented policy and appropriate support for the continuing education of medical, nursing and allied health professional staff.
- 2.3.2 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.

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 Australian Standards proclaimed by Federal and State Governments and unless otherwise approved, to the requirements for Design and Construction detailed in the Licensing Standards of the Local Authorities.
- 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 and their relatives.
- 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 and their relatives when they are not involved in therapy.

- 3.1.8 There is a meeting room suitable for case conferences.
- 3.1.9 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.
- 3.1.10 There is an occupational therapy treatment area* including space for group activities. There should also be facilities to allow for kitchen and laundry training.
- 3.1.11 There are rooms for individual therapy and consultations.
- 3.1.12 There is access to a room for the application and removal of plasters (or similar) bandages.
- 3.1.13 There is a heated hydrotherapy pool (ideally on-site) with access for people with disability.
- 3.1.14 There are appropriate storage areas for equipment.

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.

3.2 Equipment

- 3.2.1 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.
 - Equipment to provide vocational retraining.
- Where the service does not have all the equipment available on site, there are documented arrangements for referral to facilities able to provide them.
- 3.2.2 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.

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

- 4.1.1 There are clear written criteria for admission to the Rehabilitation Medicine service. These criteria are made available to referring providers.
- 4.1.2 The rehabilitation medicine service provides consultation and triage to determine appropriateness for admission into the inpatient rehabilitation program and/or advice on alternative care.
- 4.1.3 There is a clearly defined assessment procedure for each patient admitted to the hospital for rehabilitation.
- 4.1.4 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 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.
- 4.1.5 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.
- 4.1.6 There is a formal planned discharge procedure.
- 4.1.7 There is documented evidence of weekly case management meetings at which individual program plans are reviewed and these meetings involve the rehabilitation physician and appropriate allied health professionals.
- 4.1.8 All patients are offered follow-up care and review as often as it is considered necessary and practical.
- 4.1.9 Where relevant, there are established links to outpatient, day hospital and community and vocational rehabilitation services. Ideally, inpatient services will offer multidisciplinary ambulatory programs post discharge to provide continuity of care.
- 4.1.10 There are documented policies for liaison with community-based services to ensure continuity and coordination of care.
- 4.1.11 There are processes to ensure that patients who are capable of returning to work are provided with the best opportunity to do so.
- 4.1.12 There is a documented policy and evidence of ongoing consultation and communication with referring and treating healthcare practitioners.
- 4.1.13 There are documented policies for all procedures within the facility and there is evidence that these are updated regularly.

- 4.1.14 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 and/or transfer.

4.2 Management of patient records

- 4.2.1 There are secure storage and retrieval systems for patient records. 4.2.3 Records are retained and accessible for the statutory required periods.
- 4.2.2 Confidentiality of records is maintained. 4.2.4 A register of patients is maintained in a clearly defined order.

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 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 process such as the Equip (Evaluation and Quality Improvement Program) process of the Australian Council of HealthCare Standards (ACHS) or other recognised approach. 5.3 The service should regularly document the AFRM Rehabilitation Medicine Clinical Indicators.
- 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 the national database held and managed by AROC. 5.4 Feedback is actively and regularly sought from customers* of the service.
- *Note: Customers include patients, 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 Research

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

- 6.1 The service participates in under-graduate and post-graduate medical, nursing and allied health service teaching programs. 6.3 The staffing levels outlined in section 2 of these standards (Staffing) do not include time required for teaching and research activities.
- 6.2 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.

ACKNOWLEDGEMENT

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The Royal Australasian
College of Physicians

About The Royal Australasian College of Physicians (RACP):

The RACP trains, educates and advocates on behalf of more than 13,500 physicians – often referred to as medical specialists – and 5,000 trainees, across Australia and New Zealand. The College represents more than 32 medical specialties including 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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