



The Royal Australasian
College of Physicians



Australasian Faculty of
Rehabilitation Medicine

STANDARDS

FOR THE PROVISION OF
PAEDIATRIC REHABILITATION MEDICINE INPATIENT SERVICES
in
PUBLIC AND PRIVATE HOSPITALS

2015

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- Brain Injury Australia
- Paediatric & Child Health Division of the Royal Australasian College of Physicians

Their comments have been carefully considered in producing this document.

INTRODUCTION

In Australia, 1 in 12 children under the age of 14 years are estimated to be living with a disability. Children may be born with disabling conditions or acquire disability through illness or injury. Specialist Paediatric Rehabilitation Services have been developed in each state of Australia and in New Zealand to provide multidisciplinary rehabilitation care to help such young people achieve the best level of function. Inpatient rehabilitation is often required to provide multidisciplinary, intensive rehabilitation programs, discharge planning, family support and community reintegration.

Purpose and intent of this document:

The Australasian Faculty of Rehabilitation Medicine (AFRM) first published *Standards for the Provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals* in 2005. These standards have been used and adapted by paediatric rehabilitation specialists in health service planning. During the revision of this document in 2011, the need for a separate document for paediatric rehabilitation was identified. This was due to significant differences in 'casemix' and models of care between adult and paediatric services and the increased acuity of paediatric inpatients requiring rehabilitation.

The purpose of these standards is to guide Fellows of The Royal Australasian College of Physicians (RACP), Government, health service planners and administrators in their decision-making about the provision of Paediatric Rehabilitation Medicine Inpatient Services (PRMIS). This document thus accompanies the AFRM document *Standards for the provision of inpatient adult rehabilitation medicine services in public and private hospitals, 2011*. This document also complements the existing RACP policy, *Standards for the care of children and adolescents in health services, Sydney 2008*.

Methodology:

This document was produced by a Working Party of paediatric rehabilitation specialists (all Fellows of the RACP and of the Australasian Faculty of Rehabilitation Medicine - AFRM) in 2012-2013. Fellows were nominated from each Australian State and New Zealand and those with particular expertise in the establishment and management of paediatric rehabilitation inpatient services were invited to be on the Working Party. The group was supported by the RACP Policy & Advocacy Unit and met face to face and by teleconference throughout 2012.

A literature review (Medline and CINAHL) was undertaken in 2012 using the following search terms: 'paediatric' or 'pediatric' and 'rehabilitation' and 'inpatient'. Further searches were undertaken adding the terms 'standards' or 'guidelines'. Standards have been published for adult inpatient rehabilitation, particularly for acquired brain

injury. In most instances, these have been established by expert consensus. Few existing guidelines or standards for paediatric rehabilitation inpatient services were identified. However, extensive work has been undertaken in the United States to develop quality indicators for inpatient rehabilitation care of children with traumatic brain injury.

This document was developed by consensus within the Working Party and was informed by the available literature and expert knowledge of the existing services in Australia and New Zealand. It has been developed in consultation with the RACP Division of Paediatrics and Child Health Division and external stakeholders as detailed in the Acknowledgement section.

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 applies only to multidisciplinary PRMIS supervised by a specialist in paediatric rehabilitation medicine (Fellow of the AFRM or equivalent). The models of care and location of such services may vary (for example, dedicated 'rehabilitation' beds on acute medical or surgical wards, separate rehabilitation wards within a children's hospital or paediatric inpatient unit within a general rehabilitation setting).

The Standards are general and relate to the provision of Paediatric Rehabilitation Medicine (PRM) inpatient programs managing a range of congenital or acquired neurological, musculoskeletal and genetic conditions with functional impairments where rehabilitation is assessed to be beneficial in reducing disability.

The Standards may be applicable to more highly specialised PRM programs (for example: management of implantable devices for spasticity and dystonia), however, these services may have additional requirements which are beyond the scope of this general Standards document.

It is acknowledged that the process of rehabilitation is a continuum incorporating inpatient, outpatient, community and home-based care and support to achieve the best outcome for the individual, their family and society. Standards for the provision of Rehabilitation Medicine Services in the Ambulatory setting have also been published by the AFRM in 2014. These are available online on the AFRM website.

STANDARDS

These Standards cover the following five aspects of service provision: governance, staffing, facilities and equipment, policies and procedures, quality improvement and risk management activities and education and research.

DEMONSTRATING THE STANDARDS

1. GOVERNANCE

A specialist Paediatric Rehabilitation Medicine Inpatient Service (PRMIS) under the direction of a specialist in paediatric rehabilitation medicine (Fellow of the AFRM or equivalent) provides comprehensive, patient and family-centred multidisciplinary care for children and adolescents with acquired or congenital impairments. This care is evidenced by the establishment, in consultation with families, of achievable, developmentally appropriate treatment goals, the periodic assessment and documentation of the functional status of patients, regular case discussion within the team and family, and optimal management of concurrent medical problems and psychosocial issues. The primary objectives of care are to prevent further impairment, reduce activity limitations and optimise participation in educational, vocational and leisure pursuits including social participation with family and peers as well as achieving life roles in the community.

- 1.1 Definitions of rehabilitation medicine, medical rehabilitation and paediatric rehabilitation medicine are acknowledged as follows:

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.

Paediatric Rehabilitation Medicine (PRM) involves the provision of comprehensive rehabilitation services to children and young people

with disability due to injury or disease with the aim of enabling the highest-level possible of physical, cognitive, psychological and social functioning. Services are provided as inpatients, non-inpatients and in the community.

Paediatric Rehabilitation Medicine Inpatient Services (PRMIS) are identified units of patient care providing comprehensive rehabilitation services for inpatients with clinical management under the supervision of a specialist in paediatric rehabilitation medicine. A PRMIS aims to work with children and young people with loss of function or ability due to injury or disease to attain the highest possible level of function and participation. Working together with families as members of the multidisciplinary team, the process involves individual assessment, treatment, regular review, discharge planning and community integration. Standardised tools are used to measure various aspects of the process of rehabilitation. Establishment of goals and progress towards them are measured using a minimum of Goal Attainment Scaling (GAS) or Canadian Occupational Performance Measure (COPM), and the level of functional independence using the Functional Independence Measure for Children (WeeFIM), which is used in accordance with the measures outlined by paediatric Fellows of AFRM and in discussions with the Australasian Rehabilitation Outcomes Centre (AROC) to establish a paediatric rehabilitation medicine minimum dataset. PRMIS also provides timely liaison with appropriate services for ongoing rehabilitation in the ambulatory setting and long term follow-up of the children, young people and families referred to that service.

- 1.2 The designated PRMIS is directed by a specialist in paediatric rehabilitation medicine and each patient's clinical management is under the supervision of a rehabilitation medicine specialist. This management includes the coordination of ongoing medical and surgical care as well as leadership of the multidisciplinary team.
- 1.3 The PRMIS provides an organised system of care and is comprised of a team of clinicians from a variety of disciplines including medical, nursing and allied health professionals. The rehabilitation team is focussed on the patient and their family, with the aim to assist the child or young person to achieve their maximum level of functioning, independence, and participation in society.
- 1.4 The patient, family or caregivers and the rehabilitation team work together to establish developmentally appropriate and achievable treatment goals, and the progress of the rehabilitation program is measured against those goals using standardised measures validated for use in paediatrics.

- 1.5 There is evidence of planned, coordinated care. This includes documentation of regular multidisciplinary case discussions, family and discharge planning meetings including liaison with external agencies (for example: other nursing and allied health teams, educational providers, case managers, insurers).
- 1.6 There is measurement of functional status on admission to and at discharge from the programs in the service using a validated and standardised paediatric measure. Functional status might also be formally assessed at intervals during the inpatient episode.
- 1.7 The designated PRMIS follows a quality management process such as the national safety and quality scheme of the National Safety and Quality Health Service Standards of the Australian Commission on Safety and Quality in Health Care¹ in Australia, the Health and Disability Sector Standards (children and young people)² in New Zealand or standards from an equivalent body.
- 1.8 Policies and guidelines for the transition of adolescents with chronic health conditions into adult care must be in place.

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 General Staffing of the Paediatric Rehabilitation Medicine Inpatient Service

- 2.1.1 The staff establishment for a PRMIS 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 family-centred manner.
- 2.1.2 All staff must be trained to meet the physical, psychosocial, developmental, communication and cultural needs of the children and adolescents cared

for by the service. This includes incorporation of therapeutic play for younger children and access to educational support in school-aged children as well as support for transition to vocational services and health services for adults when needed.

- 2.1.3 All staff must comply with any statutory 'working with children' scheme and have child protection training.
- 2.1.4 All clinical staff must be trained in basic paediatric life support and principles of pain management as well as in minimisation and management of challenging behaviours.
- 2.1.5 Paediatric services require higher staffing numbers compared with adult services treating a similar impairment type for a number of reasons including:
- Age and developmental level of patients: for example, younger children require higher nursing staff ratios.
 - Models of Care: Most PRMIS in Australia exist as 'beds' within an acute ward. This facilitates earlier referral and 'in reach' so the patients are more 'acute' than if they were to transition to a separate ward or a stand-alone facility. This higher acuity necessitates higher nursing and medical staffing levels.
 - Casemix: Most PRMIS manage patients with a range of conditions with recently acquired neurological disorders, such as acquired brain and spinal cord injury, being most common. These acute conditions typically require high levels of staffing.
 - Smaller patient numbers, range of ages and developmental levels frequently necessitate individualised therapy limiting opportunities for therapeutic strategies such as the use of group therapy.

Medical Staff

- 2.1.6 Each 10 inpatient beds within the paediatric rehabilitation medicine service should have at minimum 2.6 FTE medical staff (consensus recommendation). This should comprise a combination of senior and junior staff including:

Paediatric rehabilitation specialist (FRACP, FAFRM or equivalent): Role includes assessment prior to admission to rehabilitation program, medical management and liaison with other specialists during the inpatient stay, supervision and teaching of junior medical staff and leadership of the inpatient multidisciplinary team. Time required for outpatient follow-up of patients and for administration not directly related to the inpatient workload is excluded.

1. For further information, please visit: <http://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards> [last accessed 19/06/14]

2. For further information, please visit: <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards> [last accessed 19/06/14]

Junior medical staff (Fellow, registrar, Resident Medical Officers (RMO)): Specific staffing numbers for junior medical staff will vary depending upon the casemix of the service, the acuity of patients and the need to participate in an after-hours roster. The minimum recommendation applies only to the provision of direct inpatient care (for example: attending to the individual medical needs of patients, ward rounds, case and family conferences, documentation in patient notes and discharge reports). The recommendation excludes time required for outpatient follow-up of patients, outpatient clinics or that committed to an after-hours roster for patients other than those of the rehabilitation service.

Where junior medical staff have clinical loads in addition to the rehabilitation service (for example: acute medical teams, neurology), their FTE for the rehabilitation medicine service should be protected.

Other medical specialty staff: The paediatric rehabilitation medicine service must have timely access to a range of other medical specialists (for example: paediatric neurologists, general and other specialist paediatricians, neurosurgeons, orthopaedic surgeons, pain specialists, psychiatrists). This may take the form of regular scheduled consultation within the paediatric rehabilitation medicine service or the ability for patients to be seen rapidly in existing outpatient services or to receive emergency consultation(s) as required.

- 2.1.7 After hours roster: A paediatric rehabilitation medicine service must have adequate medical staffing to provide appropriately supervised medical care to inpatients after-hours.
- 2.1.8 Commitment to physician training: A PRMIS should aim to obtain accreditation as a suitable training setting for registrars undergoing basic and advanced training in paediatrics and advanced training in paediatric rehabilitation medicine. Staffing levels must be adequate to support clinical supervision and teaching.

Nursing Staff

- 2.1.9 The overall nursing numbers required for 10 paediatric rehabilitation inpatients will vary depending on the model (for example: co-located within acute ward versus stand-alone facility), acuity and complexity of the patients and the mix of junior to more experienced staff. In some cases the nursing staffing may be equivalent to 10 acute paediatric medical or surgical patients (i.e.: up to 22 FTE). These figures do not include the nurse unit manager, clinical nurse consultant in rehabilitation or the rehabilitation nurse educator.
- 2.1.10 Each 10 inpatient beds within the paediatric rehabilitation medicine service should have a

minimum of 1.2 FTE senior nursing roles (consensus recommendation). 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. A clinical nurse consultant or nurse educator with specialist expertise in paediatric rehabilitation should also be employed.

- 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 and have experience in paediatrics and/or rehabilitation.
- 2.1.12 Nursing staff within a paediatric 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.
- 2.1.13 All nursing care, over the 24 hour period, must be under the supervision of a registered nurse.
- 2.1.14 The service shall have access to nursing experts such as wound, pain and stoma nurses according to the rehabilitation casemix.
- 2.1.15 There should be a preponderance of registered nurses over enrolled nurses and assistants in nursing.
- 2.1.16 Nursing staffing numbers must be adequate to support clinical supervision and teaching.

Allied Health Staff

- 2.1.17 Patients admitted to the paediatric 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 age and developmental level of the patient, the presence of co-morbid conditions, cognitive, psychological and family factors. 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 'Therapy' generally includes physiotherapy, occupational therapy, and speech and language therapy, or therapy delivered by other professional disciplines (for example: play specialists, exercise physiologists, music therapists, diversional therapists, social workers, psychologists). These therapies must be delivered by qualified and

skilled staff, or by allied health assistants under the supervision of professionally qualified staff.

2.1.19 Therapy can be delivered by a number of disciplines concurrently, particularly in interdisciplinary/transdisciplinary models.

2.1.20 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 While the staffing ratios outlined in Table 1 below are a consensus guide to the overall allied health staff numbers required, the ultimate aim must be the delivery of appropriate rehabilitative therapy. Staffing levels should be adequate to allow patients to access intensive therapy for at least 3 hours a day, 5 days a week.

2.1.22 Staffing levels must take into account both direct patient care and other 'patient attributable time' such as attending case and family conferences, ward rounds, liaison with other services and writing reports.

Table 1: Recommended allied health staff ratios for 10 paediatric rehabilitation inpatient beds in Full time Equivalents (FTE)

Health Profession	Consensus FTE
Physiotherapy	3.25
Occupational therapy	3
Allied health assistants (includes hydrotherapy)	2
Speech pathology	1.5
Social work/welfare officer	1.5
Neuropsychology	1
Clinical Psychology	1
Music therapy	0.6
Child life /play/recreation therapy	0.6
Orthotist	0.4*
Dietetics	0.25
Rehabilitation engineering	0.2**

Legend:

*Does not include cost of fabrication

** Does not include hardware

Notes:

- Consensus figures were derived by the Working Party from consultation with the Directors of all existing paediatric rehabilitation services in Australia and New Zealand. Staffing numbers were based on those used in existing paediatric rehabilitation inpatient services (in most cases 'rehab' beds within acute wards) and the figures used for the establishment of new services.
- Staffing recommendations represent the ideal number to run a generic tertiary hospital based service with a predominance of neurological rehabilitation.
- Staffing number recommendations include cover for non-clinical work, professional development and leave (30% in addition to direct patient attributable time).

2.1.23 Additional allied health requirements for specialised paediatric rehabilitation programs include:

- The services of a neuropsychologist are essential in services where patients with brain impairment are managed.
- Clinical psychologists are employed or available in all units where patients with complex behavioural issues are treated and where adjustment to disability may be an issue.
- 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. If prosthetists are not part of the employed staff establishment, then arrangements with a private provider are required.
- Access to experts in specialised seating and rehabilitation engineering is required.
- 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.
- Access to a dietetic service is required as patients in a rehabilitation medicine service frequently require review by a dietician.
- Timely access to audiology, optometry and oral health services are recommended.
- Access to interpreters is mandatory for optimal comprehension of rehabilitation, goals and overall process and to allow family-centred practice
- Where required, culturally appropriate goals and acknowledgement of cultural norms should be in place in the provision of therapy and services.

2.1.24 Allied health staffing levels must be adequate to support clinical supervision and teaching.

School and Teachers

2.1.25 All school-aged patients should have access to a school and teachers with specialist expertise whilst on an inpatient program. This includes having access to teaching staff when a patient is unable to attend a school environment for any reason.

2.1.26 As the patient's school program is integrated into the rehabilitation plan, school teachers should have the capacity to attend case conferences and form part of the multidisciplinary team.

2.1.27 Paediatric rehabilitation service staff should have the capacity to visit external education facilities and liaise with teaching staff to facilitate return to an appropriate educational setting.

Support Staff

2.1.28 Each PRMIS should have adequate numbers of support staff to ensure the effective running of the service. It is estimated that a 10 inpatient unit will require 1.0 FTE ward clerk and 1.0 FTE additional administration support (consensus recommendations).

2.1.29 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 the Australasian Rehabilitation Outcomes Centre (AROC) once available. With the advent of activity based funding, it will be necessary to increase the availability of administrative support to ensure appropriate funding of the service.

2.1.30 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.

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

2.2 Human resource management

2.2.1 The service should be 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 PRMIS will have appointed a nurse unit manager. The nurse unit manager will be responsible for the delivery of nursing services and the operational requirements of the service. In circumstances where the nursing is provided separate to the Paediatric Rehabilitation Medicine team then a clinical co-ordinator is appointed to manage in-reach services. This position may also be appointed depending on team size and patient activity.

2.2.4 Case management may be provided by a dedicated case manager or by members of the multidisciplinary team.

2.2.5 There is documented evidence of an organisational chart with reporting lines of responsibility across all members of the PRMIS including those from senior administration to the director of the service.

2.2.6 The senior clinician of each discipline reports to the director of the rehabilitation service and is responsible for the standard of clinical service provided by the practitioners in the service.

2.2.7 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.

- 2.2.8 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.
- 2.2.9 The PRMIS 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.
- 2.2.10 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 or credentialing by their professional association for non-registered professions. There is evidence that qualifications have been verified.
- 2.2.11 There is a job description for each category of professional position. This job description should be approved or agreed by the director of the service to ensure that the reporting pathways and role within the multidisciplinary team are included when employed under separate allied health departments.
- 2.2.12 Specialised procedures are undertaken only by staff with appropriate qualifications and experience and an appropriate credentialing process and quality monitoring is established.
- 2.2.13 Where the service's staffing complement does not contain a full range of the professional expertise required, there are documented arrangements to enable timely and affordable access to such resources.
- 2.2.14 Annual staff appraisals are conducted with appropriate documentation. These are performed by each staff member's discipline specific supervisor and overseen by the director.
- 2.2.15 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 three per cent 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 safe, adequate and appropriate for the rehabilitation needs of patients who may include infants, children and adolescents. Facilities should support families and care givers to remain in attendance and be involved in the patient's rehabilitation program. A rehabilitation medicine service may provide outreach and community services as a continuum of inpatient rehabilitation medicine. In this situation, relevant additional and appropriate facilities will need to be made available to the services being provided.

3.1 Facilities

- 3.1.1 The PRMIS 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. In New Zealand, the PRMIS conforms to the Health and Disability Sector Standards (Children and Young People).
- 3.1.2 Ideally adolescents should only be admitted to a designated adolescent area. Admission of adolescents must take into account their psychosocial history, relevant medical history and their suitability to be accommodated in either a paediatric or an adult ward. The risks must be assessed by the nursing unit manager in consultation with the attending physician. Consideration should also be given to the adolescent's own wishes and preferences.
- 3.1.3 In the event of an unavoidable circumstance when separate accommodation for children/adolescents and adults is not possible, the health service must identify designated areas where children and adolescents can be accommodated. Health service policies, guidelines and risk management strategies that are based on best available evidence and practice must be in place to specify the requirements for a safe and appropriate physical environment to protect the children/adolescents.
- 3.1.4 Health services must plan ahead to provide a separate physical area for accommodating unwell children and young people. This includes separate areas for the care of patients in post-traumatic amnesia or infectious conditions.
- 3.1.5 Health services should have in place forward plans to reduce average bed occupancy to 85 per cent in an effort to reduce bed block which negatively affects appropriate ward placement.
- 3.1.6 When transporting children and young people around the hospital, they must be accompanied by an appropriate person and they must not be left unattended at any time. Children and adolescents with behavioural problems, antisocial behaviours

or psychiatric conditions that pose a threat to themselves or other patients should be admitted to a specially designated area in the paediatric or adolescent ward. Where not available, reasonable options should be considered to ensure the safety of the child and other patients. A decision should be made by the nursing unit manager and/or attending physician and should include specialist paediatric and mental health consultation.

- 3.1.7 A rehabilitation medicine service provides child and adolescent specific equipment and facilities which are safe as well as designed, decorated and furnished to adequately address the needs and developmental ages of children and adolescents. The physical environment in bathrooms, therapy areas and accommodation areas must provide adequate space, fixtures (such as rails and hoists) and equipment of various sizes and designs to ensure safe mobility and personal care of children with disabilities across all levels of severity and all age groups.
- 3.1.8 There is wheelchair and pram access to all areas – wards, diagnostic facilities, therapy areas, dining and leisure areas, bathrooms, wet areas and outside areas.
- 3.1.9 There is a safe and negotiable environment for children and adolescents at all developmental levels and with cognitive, psychosocial or sensory impairments including but not exclusive to those who have visual, auditory and proprioceptive impairment.
- 3.1.10 Eating facilities are suitable to accommodate children and young people as well as their families in both form and function.
- 3.1.11 There are designated leisure and rest areas suitable for the use of patients, siblings and carers when they are not involved in therapy with suitable age appropriate, safe and hygienic toys, games and reading materials.
- 3.1.12 There is a designated area for children to attend school with materials, equipment and facilities of a similar standard as required by Australian and New Zealand schools.
- 3.1.13 There is a meeting room suitable for case conferences.
- 3.1.14 There is a physiotherapy treatment area³ with specific equipment and facilities suitable for treatments across developmental abilities and age groups. This should include open spaces where gait training, general exercises, strength and endurance training, gymnastics and recreational activities

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

may be performed. There should be safe access to stairs. There should also be indoor and outdoor areas with facilities appropriate for all forms of wheeled mobility training including self-propelled and powered wheelchair and gait retraining area suitable for children requiring gait aids and appliances.

- 3.1.15 There is a designated occupational therapy and speech therapy treatment area⁴ including space for group activities. There should also be facilities to enable training in activities of daily living (including bathing, toileting and dressing), food preparation, leisure activities as well as other domestic skills which may be desirable to practice. Access to public transport and community areas (such as shops and libraries) for therapy is desirable.
- 3.1.16 There are rooms for individual therapy and consultations, neuropsychological assessments, cognitive and social behaviour training as well as family therapy.
- 3.1.17 There is access to a room for the application and removal of plasters (or similar) and bandages.
- 3.1.18 There is access to a treatment area equipped and suitable for minor procedures.
- 3.1.19 There is a heated hydrotherapy pool (ideally on-site) with access, facilities and equipment suitable for children and adolescents with disabilities including designated and suitably private areas for changing.
- 3.1.20 There are appropriately sized storage areas for rehabilitation equipment and toys both adjacent to the patient's bed area, when regularly accessed, and in the designated therapeutic areas.
- 3.1.21 Wi-Fi capability is highly desirable to enable transmission of results and important patient information as well as progress across hospital settings using modern transportable 'smart' devices.
- 3.1.22 There are facilities to allow family members / carers to stay with the child at all times if required.
- 3.1.23 There is wheelchair accessible accommodation available for family / carers of children who live a distance from the facility. This encourages 'family-centred' care and helps to facilitate transition to an ambulatory phase of rehabilitation.

3.2 Equipment

- 3.2.1 Based on the needs of the patient casemix, a PRMIS should provide:

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

- Equipment for basic and advanced life support for all ages
 - Physical therapy equipment including:
 - o A range of wheelchairs and timely access to seating modifications
 - o Equipment to facilitate standing
 - o Gait training equipment
 - o Functional electrical stimulation equipment for patients with neurological impairment
 - o Ultrasound for musculoskeletal assessment and bladder scanner
 - o Equipment for aerobic fitness training
 - Equipment for training activities of daily living, including equipment to assist with bathing, dressing and toileting including a range of continence equipment.
 - Equipment for learning, development and recreation including a range of toys and equipment required for cognitive assessment.
 - Access to alternative and augmentative communication aids.
 - Equipment to provide vocational retraining
 - Equipment to provide education in accordance with Australian and New Zealand educational requirements.
 - Telehealth/videoconference equipment to facilitate effective distant consultations with rural and remote community services pre and post discharge from the paediatric rehabilitation service.
- 3.2.2 Where the service does not have all the above equipment available on site, there are documented arrangements for referral to facilities which able to provide them.
- 3.2.3 A rehabilitation medicine service provides information regarding community-based services to enable people with disabilities to make informed choices regarding services and equipment.

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 PRMIS. These criteria are made available to referring providers.
- 4.1.2 The PRMIS 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 including consultation with the child and/or family regarding assessment and rehabilitation planning.
- 4.1.4 There is a clearly defined assessment process for the families of each patient that clearly identifies their role in rehabilitation and the support they need to enable the patient to achieve identified rehabilitation goals.
- 4.1.5 There is a written rehabilitation plan for each patient based on the assessment. The plan is to be patient and family-centred and to 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.
- 4.1.6 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.
- 4.1.7 There is a formal planned discharge procedure including regular family/carer involvement and involvement of the child or adolescent where possible and appropriate.
- 4.1.8 There is documented evidence of weekly case management meetings at which individual program plans are reviewed. These meetings involve the rehabilitation physician, appropriate allied health professionals and take into account patient, carer and family goals
- 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 facilitate access to post intervention therapy services, outpatient, day hospital and community and vocational rehabilitation services. Ideally, inpatient services will offer multidisciplinary ambulatory programs post discharge to provide continuity of care, or refer the patient to appropriate community providers.
- 4.1.11 There are documented policies for liaison with community-based services to ensure continuity and coordination of care.
- 4.1.12 There are processes to ensure that patients returning to school are fully and appropriately supported.

- 4.1.13 There is a documented policy and evidence of ongoing consultation and communication with referring and treating healthcare practitioners.
- 4.1.14 There are documented policies for all procedures within the facility and there is evidence that these are updated regularly.
- 4.1.15 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.
- 4.2.2 Confidentiality of records is maintained.
- 4.2.3 Records are retained and accessible for the statutory required periods.
- 4.2.4 A register of patients is maintained in a clearly defined order.
- 4.2.5 Confidentiality of patient data collected for quality and risk management activities and reporting service activity is maintained. Applications to relevant ethics committees are submitted when required for research purposes.

5. QUALITY IMPROVEMENT AND RISK MANAGEMENT ACTIVITIES

The service has a quality improvement and risk management framework with projects addressing consumer involvement, access, appropriateness, effectiveness, safety and efficiency. The service will submit data to the Australasian Rehabilitation Outcomes Centre (AROC) when a paediatric dataset is established and will regularly review its performance against benchmarks.

- 5.1 Procedures exist to ensure the evaluation of the quality of the services provided. Quality management follows a process such as the National Safety and Quality Health Service Standards of the Australian Commission on Safety and Quality in Health Care in Australia or the Health and Disability Sector Standards in New Zealand.
- 5.2 Outcomes of rehabilitation are evaluated by use of standardised tools with documentation of changes in impairment, function, progress towards the achievement of goals, level of independence and measures of the processes of care. Selected procedures are also monitored with data collection and evaluation, staff feedback, institution of identified actions and follow up review. 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, once the paediatric data set is established.

- 5.3 Feedback is actively and regularly sought from clients of the service.
- 5.4 The service actively promotes the principles of evidence-based clinical practice for all professional staff employed within it.

6. EDUCATION AND RESEARCH

The service is actively engaged in continuing education and teaching and promotes the importance of research.⁵

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

5. Note: The staffing levels outlined in section two of these standards (Staffing) do not include time required for teaching and research activities.

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