Guidelines for Recognition of Private Hospital-Based Rehabilitation Services

August 2016

Developed by the Consultative Committee on Private Rehabilitation

Guidelines for Recognition of Private Hospital-Based Rehabilitation Services (The Guidelines)

Contents

Introduction

The purpose of specialist rehabilitation units in the private sector is to treat patients requiring specialist rehabilitation.

This particular group of patients, as defined in these Guidelines, requires multidisciplinary rehabilitation treatment in a specialist rehabilitation unit for the clinical intent or treatment goal of improving the functional status of a patient with an impairment, disability or handicap within a clinically appropriate timeframe.

There may be multiple entry paths (e.g. from place of residence, another hospital or hospital ward) to a specialist multidisciplinary rehabilitation service. Referral source is not an indicator of appropriateness for admission to a specialist rehabilitation service, but patients must be admitted to the services under the direction of a Consultant Physician in Rehabilitation Medicine or equivalent and be assessed as appropriate in accordance with the admission criteria in these Guidelines.

Private facilities providing multidisciplinary rehabilitation care which meet *all* the criteria in these Guidelines may be eligible for private health insurance payments.

The Guidelines have been developed in consultation with the Australasian Faculty of Rehabilitation Medicine (AFRM) a Faculty of the Royal Australasian College of Physicians. They have also been endorsed by the Consultative Committee on Private Rehabilitation (CCPR), which has independent industry Representation[1].

The industry recognizes the Functional Independence Measure (FIM) as the functional measure of choice for inpatient rehabilitation, thus ensuring industry data requirements are met as defined by the Australasian Rehabilitation Outcomes Centre (AROC).

It is intended that the Guidelines will guide hospitals and health insurers in their contract negotiations. The definition of a rehabilitation patient is also relevant and can be found in Schedule 1, Part 2, 8 of the *Private Health Insurance (Benefit Requirements) Rule*s made under the *Private Health Insurance Act 2007*.

In addition, these Guidelines are a component of the quality criteria for private hospital and day hospital facilities with rehabilitation services seeking eligibility for Second Tier default benefits.

These Guidelines have been developed for the delivery of private rehabilitation services. They may also be of assistance to State and Territory health authorities in the treatment of private and public patients in public hospitals.

It is anticipated that the elements in these requirements will be reviewed biennially by the CCPR.

[1] The Consultative Committee on Private Rehabilitation is a national industry committee comprising representatives of the Australasian Faculty of Rehabilitation Medicine, Private Healthcare Australia, the Australian Private Hospitals Association, the Department of Veterans' Affairs and the Private Health Insurance Ombudsman.

Criterion 1

Rehabilitation care provided by a specialist rehabilitation team on an admitted or non-admitted patient basis in a specialist rehabilitation unit (a separate physical space).

1.1. Specialist Rehabilitation Team

1.1.1. Rehabilitation care must be provided by a multidisciplinary team which is defined as:

- a medical practitioner who is a Consultant Physician in Rehabilitation Medicine and who is a Fellow of the Australasian Faculty of Rehabilitation Medicine (Royal Australasian College of Physicians) or equivalent[2];
- nursing staff skilled and experienced in rehabilitation nursing, appropriate to the rehabilitation casemix of the hospital;
- allied health professionals with relevant experience, including FIM credentialing and registered or recognised by the appropriate professional bodies, appropriate to the rehabilitation casemix of the hospital; and
- delivery of defined and documented rehabilitation programmes, reviewed as appropriate.

The Consultant Physician in Rehabilitation Medicine is responsible for the co-ordination of treatment for each patient.

1.2. Specialist Multidisciplinary Rehabilitation Service

1.2.1. Rehabilitation care should be provided in a dedicated facility/unit/ward. It is generally not recommended that overnight inpatient rehabilitation patients will be accommodated outside the dedicated rehabilitation unit/ward other than in situations of short term unavoidable operational requirements.

The design of the facility/unit will be dependent on the casemix of the facility/unit. However, the following features will be included:

- disability access to all areas including bed units, wards, dedicated rooms for individual therapy, dining rooms, toilets and accessible outside areas;
- a physiotherapy area with appropriate equipment and which has dedicated rooms for individual therapy and assessment as well as large open space for gait training and general exercise;
- an occupational therapy area that has space for group activities, rooms for individual therapy and assessment, a therapy workshop and dedicated areas for community assessment of Activities of Daily Living (ADL);

[2] There may be circumstances in which an alternative qualification to AFRM or equivalent is appropriate, such as where:
- patients are receiving sub-specialty rehabilitation and the qualifications and experience of the medical specialist are applicable to the casemix of the programme; or patients are receiving sub specialty specialty rehabilitation and the qualifications and experience of the medical specialist are applicable to the casemix of the programme; or
- the specialist has extensive experience in rehabilitation.is an experienced physician or surgeon experienced in multidisciplinary rehabilitation medicine.

- individual therapy or consultation areas suitable for quiet clinical consultation or mental state examination or speech therapy, assessment and treatment or psychological assessment, counselling and treatment where appropriate;
- a meeting room suitable for case conferences and family meetings;
- hydrotherapy pool conforming to the relevant Australian Design Standards (if hydrotherapy is appropriate for casemix). In circumstances where hydrotherapy is recommended for individual patients as per their treatment plans and the hospital does not have hydrotherapy pool on site, it must be able to demonstrate that safe and appropriate access to a hydrotherapy pool is available.

1.3. Equipment

1.3.1. The facility/unit's equipment will be dependent on the casemix of the facility/unit:

- parallel bars;
- ergometer, and treadmill calibrated to measure distance/units;
- gym equipment, including weights, pressures and pulleys, suitable for muscle strengthening;
- an area and equipment for provision of personal and domestic ADL training;
- range of wheelchairs and mobility aids;
- appropriate mental state and cognitive screening and assessment tools;
- appropriate speech and language assessment and treating tools;
- appropriate tools for patient and family education; and
- stairs with handrails and turning area at top of stairs.

1.4 Rehabilitation Settings

Rehabilitation services may be provided on an admitted or non-admitted basis including the continuum of services between inpatient and ambulatory settings according to the medical and functional requirements of the patient[3].

This ensures the efficient running of the service and assists with early discharge home whilst maximising functional outcomes. Where overnight inpatient multidisciplinary rehabilitation is not clinically indicated, multidisciplinary rehabilitation may be offered through a full Day Rehabilitation Programme, a Half-Day Rehabilitation Programme or a Sessional Therapy Programme.

It should be noted that, within an episode of care, a patient's rehabilitation needs may vary, and that, for example, patients who are receiving a day programme may move progressively between full-day, half-day and sessional programmes. Clinical assessment will direct the appropriate selection of programmes for a patient.

For the purposes of these *Guidelines*, a *session* is defined as functional task management by an appropriately qualified health professional over a period which approximates 30 minutes.

[3] Due to differing definitions of admitted and non-admitted care in different states of Australia for their respective data collections, Day Rehabilitation Programmes may be named variously as 'same day' 'day only' 'half day' or 'non-admitted' episodes of care according to the location of the facility. The relevant State legislation, guidelines or operational directives will determine whether the patient is admitted or non-admitted

1.4.1 Full-Day Rehabilitation Programme

Day Rehabilitation Programmes[3] are suitable for those patients who have established rehabilitation needs, do not require overnight inpatient care, and whose rehabilitation programmes and goals require the involvement of a multidisciplinary team, under the direction of a Consultant Physician in Rehabilitation Medicine or equivalent. Day Rehabilitation Programmes provide a coordinated programme of care on an admitted or non-admitted same day basis which is documented in an individualised multidisciplinary rehabilitation plan which includes negotiated rehabilitation goals and indicative time frames. The number of sessions associated with a full-day rehabilitation programme will be more than 5 sessions.

1.4.2 Half-Day Rehabilitation Programme

Half-day Rehabilitation Programmes[3] are suitable for those patients who have established rehabilitation needs, do not require overnight inpatient care, and whose rehabilitation programmes and goals require the involvement of a multidisciplinary team, under the direction of a Consultant Physician in Rehabilitation Medicine or equivalent. Half-Day Rehabilitation Programmes provide a coordinated programme of care on an admitted or non-admitted same day basis which is documented in an individualised multidisciplinary rehabilitation plan which includes negotiated rehabilitation goals and indicative time frames. The number of sessions associated with a half-day rehabilitation programme will be 3 to 5 sessions.

1.4.3 Sessional Therapy Programme

When a patient has established rehabilitation needs and goals as determined by a Consultant in Rehabilitation Medicine or equivalent, does not require overnight inpatient care and requires a single mode of therapy not involving the coordination of multidisciplinary care, such needs may be met through a Sessional Therapy Programme[3]. A Sessional Therapy Programme provides a single modality of therapy of up to 2 sessions in a given day which is documented in an individualised rehabilitation plan which includes negotiated rehabilitation goals and indicative time frames.

1.4.4 Inpatient Rehabilitation Programme

Inpatient Rehabilitation Programmes are suitable for those patients who have established rehabilitation needs, but who are also assessed as requiring 24 hour nursing care. Their rehabilitation programs and goals require the involvement of a multidisciplinary team, under the direction of a Consultant in Rehabilitation Medicine or equivalent and should be confirmed with the patient on admission. The multi-disciplinary service will be available 7 days per week ensuring specialist rehabilitation care is available regardless of day of admission.

Inpatient Rehabilitation Programmes provide a daily coordinated programme of care that is documented in an individualised multidisciplinary rehabilitation plan and which includes negotiated rehabilitation goals and indicative time frames.

[3] Due to differing definitions of admitted and non-admitted care in different states of Australia for their respective data collections, Day Rehabilitation Programmes may be named variously as ‘same day’ ‘day only’ ‘half day’ or ‘non-admitted’ episodes of care according to the location of the facility. The relevant State legislation, guidelines or operational directives will determine whether the patient is admitted or non-admitted.

Criterion 2

Rehabilitation care provided by a multidisciplinary team which is under the clinical management of a Consultant Physician in Rehabilitation Medicine or equivalent.

2.1. Clinical Staffing

2.1.1. Rehabilitation care must be provided by a multidisciplinary team.

2.1.1.1. The multidisciplinary rehabilitation team will be under the clinical direction of a Consultant Physician in Rehabilitation Medicine or equivalent[4].

Each programme shall be supervised by a Consultant Physician in Rehabilitation Medicine or equivalent and staffed by an appropriately qualified multidisciplinary team relevant to the therapeutic needs of the patients being treated and have access to consultative services which are appropriate to the programmes offered.

2.1.1.2. Other clinical staff, both professional and support staff, will be appropriately skilled, experienced and provided in sufficient numbers to provide individual and group therapy programmes for the casemix of patients being serviced.

2.2. Policy and Programme Review

2.2.1. A facility/unit must have:

- a comprehensive manual of policy and procedures applying to and within the facility, and there should be evidence that this is reviewed on an annual basis and updated as per accreditation requirements or legislative changes;
- a demonstrated process for reviewing programmes and patient outcomes.

[4] There may be circumstances in which an alternative qualification to AFRM or equivalent is appropriate, such as where:
- patients are receiving sub-specialty rehabilitation and the qualifications and experience of the medical specialist are applicable to the casemix of the programme, or
- the specialist is an experienced physician or surgeon experienced in multidisciplinary rehabilitation.

2.3. Data Collection and Outcome Measures

2.3.1. A facility/unit must:

- submit rehabilitation data in AN-SNAP3[5] format (or update versions) to the Australasian Rehabilitation Outcomes Centre (AROC) targeting 100% of all in-patient rehabilitation episodes for assessment and national benchmarking;
- ensure all rehabilitation episodes will be scored for Functional Independence Measure (FIM) by a FIM-credentialed staff member.

[5] Australian National Sub-Acute and Non-Acute Patient classification system.

Criterion 3

Rehabilitation care provided for a person with impairment or disability and for whom there is reasonable expectation of functional gain.

3.1. Impairment Codes

3.1.1. Each patient is assigned an impairment code using the current version of the AROC Impairment Coding Guidelines. These guidelines were originally based on the UDSmr Guidelines. The 2013 AROC Guidelines is available on line: http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow125260.pdf

Classifications include:

- stroke
- brain dysfunction
- neurological conditions
- spinal cord dysfunction
- amputation of limb
- arthritis
- chronic pain
- orthopaedic disorders
- cardiac
- pulmonary disorders
- burns
- congenital deformities
- major multiple trauma
- developmental disabilities
- reconditioning/restorative
- other disabling impairments.

3.1.2. The episode should be classified according to the primary clinical reason for the **current episode** of rehabilitation care. The AROC impairment code identifies the major focus of rehabilitation and the primary subject of the rehabilitation plan.

Criterion 4

Rehabilitation care for which the primary treatment goal is improvement in functional status.

4.1. Assessment and Admission

4.1.1. Rehabilitation care must be provided for a person who has all of the following:

- an impairment with associated functional loss;
- a reasonable expectation of functional gain; and
- the primary treatment goal is improvement in functional status.

4.1.1.1. Acceptable rehabilitation impairments are the current version of the AROC Impairment Codes as described in the AROC Impairment Coding Guidelines 2013 http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@aroc/documents/doc/uow125260.pdf

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4.1.1.2. Prior to commencement of the rehabilitation programme, a comprehensive and documented rehabilitation assessment should be undertaken.

4.1.1.3. Appropriate outcome measures must be used to document initial assessment of functional ability for all patients.

4.1.1.4. The pre-admission assessment should also indicate that the patient has an understanding of and commitment to the rehabilitation process.

4.1.1.5. The pre-programme assessment will take into account the most appropriate hospital-based setting for rehabilitation care.

4.2. Admission Guidelines

4.2.1 Programmes offered by private rehabilitation facilities that meet these Guidelines would be expected to include the features described in Appendix 1: Standardised Nomenclature and Admission Guidelines for Rehabilitation Patients in Private Facilities.

4.2.2 Admissions to a rehabilitation programme should conform to the admission criteria of that programme as set out in Appendix I

Criterion 5

Rehabilitation care which is <u>evidenced in the medical record by</u>:

- **an individualised and documented initial and discharge assessment of functional ability by use of a recognised functional assessment measure;**
- **an individualised multidisciplinary rehabilitation plan which includes negotiated rehabilitation goals and indicative time frames; and**
- **hospital-specific documented programmes or treatment plan**

5.1. Assessing Functional Ability

5.1.1. Appropriate outcome measures must be used to document admission and discharge assessment of functional ability.

5.1.2. Utilisation of other standardised outcome instruments dependent on casemix.

5.2. Development and implementation of a Multidisciplinary Rehabilitation Programme for each individual patient.

5.2.1. A written patient specific rehabilitation plan must be developed by the multidisciplinary team and include:

- clearly stated multidisciplinary goals and outcomes of the planned rehabilitation;
- predicted period of rehabilitation (length of stay);
- functional gain;
- discharge destination;
- reflect the needs of the patient, family and carers as well as all members of the multidisciplinary team; and
- meeting industry-accepted reporting requirements (for example the relevant Clinical Indicators developed by the Australian Council on Healthcare Standards).

5.2.2. For patient review and multidisciplinary care conferences:

- there must be regular meetings whilst the patient is in a rehabilitation programme;
- there must be a documented policy for regular review of patients;
- this policy must include regular interdisciplinary case conferences which evaluate and document the progress of the patient against the established plan.in the medical record. The patient, family members and carers should be kept informed and contribute to the decisions of the rehabilitation team.

5.3. Discharge Planning

5.3.1. All patients will have a comprehensive documented discharge plan. This discharge plan must

be commenced and documented on admission and activated on discharge. The discharge plan will take into account:

- the needs of the patient and family;
- home assessment where appropriate;
- relevant discharge destination end point;
- liaison with community services and communication with the referring doctor and Local Medical Officer; and
- ongoing treatment requirements and care setting.

A copy of the discharge plan will be sent to the patient's General Practitioner and will include details of medications currently prescribed for the patient.

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APPENDIX 1

STANDARDISED NOMENCLATURE and ADMISSION GUIDELINES for REHABILITATION PATIENTS IN PRIVATE FACILITIES

Note: These Guidelines apply to rehabilitation facilities and services that meet the Guidelines for Recognition of Private Hospital-Based Rehabilitation Services

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Orthopaedic Programme

Upper Limb	Joint Replacement
Lower Limb Complex	Spinal – post surgical

1. UPPER LIMB ORTHOPAEDIC PROGRAMME

Clinical Criteria for Admission:

1. Following upper limb orthopaedic procedures, trauma, injuries or fractures which directly result in disability which requires a rehabilitation programme targeted at developing skills in personal activities of daily living.

OR

2. Patient fitted with an upper limb orthosis – this may require a short term rehabilitation programme directed at developing skills in personal activities of daily living.

OR

3. The patient has co-morbidities which result in the need for rehabilitation

Including, but not limited to:

a. Significant balance problems where walking aid is ordinarily held by the affected arm.
b. Widespread generalised arthritis.
c. Neurological or cognitive dysfunction.

OR

4. Access Indications – Because of upper limb orthopaedic procedures there are mobility and balance changes resulting in safety problems which would benefit from multidisciplinary rehabilitation treatment.

OR

5. The presence of post-operative complications which restrict function.

AND

6. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

2. LOWER LIMB ORTHOPAEDIC

Clinical Criteria for Admission

1. Following lower limb orthopaedic procedures, trauma, injuries or pelvic fractures which result in disability which requires a rehabilitation programme directed at developing skills in personal activities of daily living.

OR

2. Fractures requiring acquisition of specific balance or mobility skills for safety.

OR

3. Bilateral weight bearing limb fractures.

OR

4. Multiple fractures with major trauma.

OR

5. Lower limb fractures with co-morbidities which result in the need for rehabilitation;

   Including, but not limited to:

   a. Widespread generalised rheumatoid or osteoarthritis.
   b. Significant balance problems – which includes Parkinson's disease, early Alzheimer's disease and other neurological and cognitive dysfunctions, vestibular problems, previous stroke.
   c. Factors which effect ability to weight bear with appropriate aid – such as other joint, replacements, status of upper limb joints, significant respiratory or cardiac disease.
   d. Post-operative complications.

OR

6. Access Indications – Because of lower limb orthopaedic procedures there are mobility and balance changes resulting in safety problems which would benefit from multidisciplinary rehabilitation.

AND

7. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

3. JOINT REPLACEMENT

Clinical criteria for Admission:

1. Lower limb joint replacement with or without local complications of the procedure which result in disability which requires a rehabilitation programme directed at developing skills in personal activities of daily living.

OR

2 Lower limb joint replacement with co-morbidities which result in the need for rehabilitation,

Including but not limited to:

a. Widespread generalised rheumatoid or osteoarthritis.
b. Significant balance problems – which includes Parkinson's disease, early Alzheimer's disease, vestibular problems, previous stroke.
c. Factors which effect ability to weight bear with appropriate aid – such as other joint replacements, status of upper limb joints, significant respiratory or cardiac disease.
d. Patients that have difficulty in complying with safety instructions to ensure the protection of the new joint.
e. Neurological or cognitive dysfunctions.

OR

3 Access indications – such that the lower limb joint replacement causes mobility changes which result in balance and safety issues.

AND

4 The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

4. SPINAL – POST SURGICAL

Clinical Criteria for Admission

1. Following spinal surgery or spinal intervention such as laminectomy

AND

2. The patient has persisting disability and dependency due to:

    2.1 Post-operative complications which restrict function.

    OR

    2.2 Co-morbidities which result in the need for rehabilitation because of balance and safety issues.

    OR

    2.3 Impairment in muscle strength, joint instability (e.g. Halo brace), limited and painful range of movement, disturbance of peripheral joint sensation, postural and gait dysfunction.

    OR

    2. 4 A condition which results in disability which requires a rehabilitation programme directed at developing skills in personal activities of daily living.

    OR

    2.5 Access Indications – Because of spinal intervention there are mobility and balance changes resulting in safety problems which would benefit from multidisciplinary rehabilitation.

AND

3 The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

Neurological Programme

Non Stroke – e.g.: Parkinson's & Extra Pyramidal Disorders	
Non Stroke - Peripheral	Traumatic brain
Non Stroke – Neurological	Non traumatic brain
Stroke	

1. NON STROKE – PARKINSON'S & EXTRA PYRAMIDAL DISORDERS

Clinical Criteria for Admission

Indications are:

1. Recent onset or deterioration in mobility and function requiring medication manipulation as an adjunct to the rehabilitation received.

OR

2. Parkinson's disease / Extra pyramidal disorders with:

    2.1 Recurrent falls + sequelae.

    OR

    2.2 Swallowing disorders with subsequent problems, e.g. Dietary, chest Infection.

    OR

    2.3 Communication disorder.

AND

4 The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

2. NON STROKE – PERIPHERAL

Clinical Criteria for Admission

1. The patient has suffered a recent onset of neurological condition.

OR

2. The patient has suffered deterioration of functional ability in association with an established neurological condition.

   Including but not limited to:

   a. Guillain-Barre' Syndrome.
   b. Other Neuropathies.
   c. Myopathies.
   d. Peripheral Nerve injuries.

AND/OR

3. The disability is assessed as being likely to respond to rehabilitation.

AND

4 The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

3. NON STROKE – NEUROLOGICAL

Clinical Criteria for Admission

1. The patient has suffered deterioration of functional ability in association with an established neurological condition

   Including but not limited to:

   a. Multiple sclerosis.
   b. Other Multi focal conditions.

   This would exclude conditions that primarily manifest as dementia e.g. Alzheimer's disease

OR

2. The patient has persisting disability and dependency due to:

   2.1. Nerve root damage.

   OR

   2.2 Spinal Cord damage including Cauda Equina syndrome involving bladder or bowel.

AND/OR

3. The disability is assessed as being likely to respond to rehabilitation.

AND

4. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

4 STROKE

Clinical Criteria for Admission:

1. The patient has suffered a recent onset of stroke with functional loss

OR

2. The patient has suffered deterioration of functional ability following a previous stroke.

AND/OR

3. The disability is assessed as being likely to respond to rehabilitation.

AND

4. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

5. TRAUMATIC BRAIN INJURY

Clinical Criteria for Admission

1. The patient has suffered a recent traumatic brain injury.

AND/OR

2. The patient's impairment (cognitive, behavioural and/or communicative impairment) is such that the functional deficit requires specific care which cannot be safely provided at home or in an outpatient setting.

AND/OR

3. The patient and/or carer requires intensive daily therapy in a multidisciplinary setting.

AND/OR

4. The disability is assessed as being likely to respond to rehabilitation.

AND

5. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

6. NON TRAUMATIC BRAIN INJURY

Conditions causing brain injury including but not limited to hypoxia, post-surgical infection, post sub-arachnoid haemorrhage, and following neurosurgery for brain tumour.

Clinical Criteria for Admission

1. The patient has suffered a recent brain injury or brain surgery or emerges from coma or vegetative state.

OR

2. The patient has experienced a recent or progressive deterioration in functional capability following previous non traumatic brain injury.

AND

3. The patient's impairment (cognitive, behavioural and/or communicative impairment) is such that the functional deficit requires specific care which cannot be safely provided at home or in an outpatient setting.

AND/OR

4. The patient requires intensive daily therapy in a multidisciplinary setting.

AND

5. The disability is assessed as being likely to respond to rehabilitation.

AND

6. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

Pain Programme

Clinical Criteria for Admission:

1. Diagnosis of chronic/intractable pain condition or patient pain levels and medication use resulting in a deficit in balance, mobility and functioning which requires multidisciplinary intervention.

AND

2. Assessment indicates the patient is in an appropriate psychological state to participate, with potential for positive response to intervention.

AND/ OR

3. Aiming to avoid surgical intervention and minimise/rationalise medication use.

AND/OR

4. The disability is assessed as being likely to respond to rehabilitation.

AND

5. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

Re-conditioning Programme

Clinical Criteria for Admission:

Where a rehabilitation programme aims to maximise or restore functional independence, exercise tolerance and endurance in a patient who is deconditioned:

1. Following an acute surgical intervention.

OR

2. Following an acute medical condition or exacerbation

   Including, but not limited to:

   a. Septicaemia.
   b. Renal failure.
   c. Liver failure.
   d. Cardiac or respiratory illness.

OR

3. Patient is experiencing an acute exacerbation of inflammatory arthritis (e.g. As evidenced by multiple joints, ESR elevation, mobility of upper and lower limbs diminished) with concurrent disability.

OR

4. Following exacerbation of chronic illness.

OR

5. Patient is deconditioned as a result of cancer or following treatment from cancer.

AND

6. The acute episode has resulted in a functional deterioration to a level that the patient requires support and guidance with basic ADL tasks and/or increased inability to transfer and ambulate.

AND

7. The patient's disability is assessed as being likely to respond to multidisciplinary rehabilitation therapy within appropriate time frames and the rehabilitation therapy is not part of respite care.

AND

8. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

Amputee Programme

Clinical Criteria for Admission:

1. Below Knee Amputation (transtibial), Symes, Through Knee Amputation, Above Knee Amputation (transfemoral), Above Elbow Amputation and Below Elbow Amputation or higher complication.

OR

2. Bilateral amputations.

OR

3. Functional education and training for prosthesis.

OR

4. Any of the above amputation or fracture with other significant co-morbidities, including, but not limited to stroke, rheumatoid arthritis, cardiac diseases.

OR

5. Following amputation:

   Failed stump healing or wound breakdown.

   OR

   Debilitating amputation-related pain.

   OR

   Contractures restricting mobility.

   OR

   Phantom pain.

AND

6. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.

Cardiac Programme

Clinical Criteria for Admission:

Where a rehabilitation programme aims to maximise or restore functional independence, exercise tolerance and endurance:

1. Following a recent cardiac event.

AND

2. The patient is medically stable:

    - Post-operative cases afebrile for 48 hours
    - No arrhythmia changes for 48 hours
    - Wounds are sound
    - Cardiac Failure controlled and stabilised
    - Angina controlled and stabilised

AND/OR

3. There is associated persisting disability and dependency following the cardiac event e.g.:
    - Recent Stroke,
    - Respiratory Compromise,
    - Significant Comorbidities e.g. Generalised Arthritis, previous Stroke.

AND

4. The Patient's disability is assessed as being likely to respond to multidisciplinary rehabilitation, with rehabilitation goals being identified, within appropriate timeframes.

AND

5. The patient is able to actively participate in a rehabilitation programme with or without the aid of a carer.