Guidelines for Recognition of Private Hospital-Based Rehabilitation Services

August 2012

Developed by the Consultative Committee on Private Rehabilitation
Guidelines for Recognition of Private Hospital-Based Rehabilitation Services (The Guidelines)

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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 multi disciplinary 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.

There may be multiple entry paths (e.g. from place of residence, another hospital or hospital ward) to a specialist rehabilitation hospital. Referral source is not an indicator of appropriateness for admission to a specialist rehabilitation unit, but patients must be admitted by a medical practitioner and be assessed as appropriate in accordance with the admission criteria in these Guidelines.

Private facilities providing rehabilitation care which meet all the criteria in these Guidelines will be eligible for private health insurance payments. Health insurers undertake to use reasonable endeavours to ensure that claims from facilities meeting these Guidelines and any other legislative and negotiated Agreement requirements are paid in a timely manner.

The Guidelines have been developed in consultation with the Royal Australasian College of Physicians’ Australasian Faculty of Rehabilitation Medicine (AFRM). They have also been endorsed by the Consultative Committee on Private Rehabilitation (CCPR), which has independent industry Representation1.

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) Rules* made under the *Private Health Insurance Act 2007*.

In addition, the 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 bi-ennially by the CCPR.

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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;
- nursing staff skilled and experienced in rehabilitation nursing, appropriate to the rehabilitation casemix of the hospital;
- allied health professionals with relevant experience and registered or recognised by the appropriate professional bodies, appropriate to the rehabilitation casemix of the hospital; and
- delivery of defined and documented rehabilitation programs, reviewed as appropriate.

1.2. Specialist Rehabilitation Unit

1.2.1. Rehabilitation care should be provided in a separate dedicated facility/unit/ward. It is generally not recommended that 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-speciality rehabilitation and the qualifications and experience of the medical specialist are applicable to the casemix of the program; or
- the specialist has extensive experience in rehabilitation.
- 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 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 or as a continuum of services in inpatient and non-inpatient settings according to the medical and functional requirements of the patient.

This ensures the efficient running of the service and assists with early discharge home whilst maximising functional outcomes. Where a non-inpatient program is suitable, rehabilitation may be offered through a Day Rehabilitation Program, a Half-Day Rehabilitation Program or a Sessional Therapy Program.

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 program may move progressively between one day, half-day and sessional programs.

For the purposes of these Guidelines, a session is defined as functional task management by an allied health professional or equivalent over a period which approximates 30 minutes.
1.4.1 Full-Day Rehabilitation Program

Day Rehabilitation Programs\(^3\) are suitable for those patients who have established rehabilitation needs, do not require overnight inpatient care, and whose rehabilitation programs and goals require the involvement of a multidisciplinary team, under the direction of a Consultant in Rehabilitation Medicine or equivalent. Day Rehabilitation Programs provide a coordinated program of care on a non-inpatient 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 program will be more than 5 sessions.

1.4.2 Half-Day Rehabilitation Program

Half-day Rehabilitation Programs are suitable for those patients who have established rehabilitation needs, do not require overnight inpatient care, and whose rehabilitation programs and goals require the involvement of a multidisciplinary team, under the direction of a Consultant in Rehabilitation Medicine or equivalent. Half-Day Rehabilitation Programs provide a coordinated program of care on a non-inpatient 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 program will be 3 to 5 sessions.

1.4.3 Sessional Therapy Program

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 requiring the coordination of multidisciplinary care, such needs may be met through a Sessional Therapy Program. A Sessional Therapy Program provides a single modality of therapy of up to 2 sessions in a given day on a non-inpatient basis which is documented in an individualised rehabilitation plan which includes negotiated rehabilitation goals and indicative time frames.

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\(^3\) Due to differing definitions of admitted and non-admitted care in different states of Australia for their respective data collections, Day Rehabilitation Programs may be named variously as ‘same day’ ‘day only’ ‘half day’ or ‘non-admitted’ episodes of care according to the location of the facility.
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 management of a Consultant in Rehabilitation Medicine or equivalent\(^4\).

Each program shall be supervised by a Consultant in Rehabilitation Medicine and staffed by an appropriately qualified multidisciplinary team relevant to the therapeutic needs of the patients being treated and have access to consultative services appropriate to the programs 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 programs for the casemix of patients being serviced.

2.2. **Policy and Program 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 programs 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-speciality rehabilitation and the qualifications and experience of the medical specialist are applicable to the casemix of the program; or
- the specialist has extensive experience in rehabilitation
2.3. **Data Collection and Outcome Measures**

2.3.1. A facility/unit must:

- submit rehabilitation data in AN-SNAP3\(^5\) format to the Australian Rehabilitation Outcomes Centre (AROC) for assessment and national benchmarking;
- have appropriately credentialed staff for use of any assessment tools required by AROC; and
- have an appropriate number of staff credentialed.

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\(^5\) 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 using the current version of UDS 6-digit code guidelines.

Classifications include:

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

3.1.2. The 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:

- an impairment and a disability;
- 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 Version 4 Impairment Codes in UDS for Medical Rehabilitation.

4.1.1.2. Where possible, prior to commencement of the rehabilitation program, 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-program assessment will take into account the most appropriate hospital-based setting for rehabilitation care.

4.2. Admission Guidelines

4.2.1 Programs 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.
Criterion 5

Rehabilitation care which is evidenced in the medical record by:

- 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 programs 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. Preparation of an Individualised Multidisciplinary Rehabilitation Plan

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 program;
   - 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.
Guidelines for Recognition of Private Hospital-Based Rehabilitation Services

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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1. **UPPER LIMB ORTHOPAEDIC PROGRAM**

*Clinical Criteria for Admission:*

1. Following upper limb orthopaedic procedures, trauma, injuries or fractures which result in disability which requires a rehabilitation program directed 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 program 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 multi-disciplinary rehabilitation treatment.

OR

5. The presence of post-operative complications which restrict function.
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 program directed at developing skills in personal activities of daily living.

OR

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

OR


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 multi-disciplinary rehabilitation.
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 program 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.
   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.
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 program 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 multi-disciplinary rehabilitation.
Neurological Program

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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 and/or intensive rehabilitation to improve mobility and function.

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.
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 program.
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.

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 program.
4  STROKE

Clinical Criteria for Admission:

1. The patient has suffered a recent onset of stroke

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 program.
5. TRAUMATIC BRAIN INJURY

Clinical Criteria for Admission

1. The patient has suffered a recent 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 requires intensive daily therapy in a multi-disciplinary 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 program.
6. **NON TRAUMATIC BRAIN INJURY**

Conditions causing brain injury including but not limited to hypoxia, post surgical infection, post subarachnoid 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 multi-disciplinary 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 program.
Pain Program

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 multi disciplinary 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 program.
Re-conditioning Program

Clinical Criteria for Admission:

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

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 has neoplasm of non-cortical origin or involvement.

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 the program.
Amputee Program

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.
Cardiac Program

Clinical Criteria for Admission:

Where a rehabilitation program 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 the program.