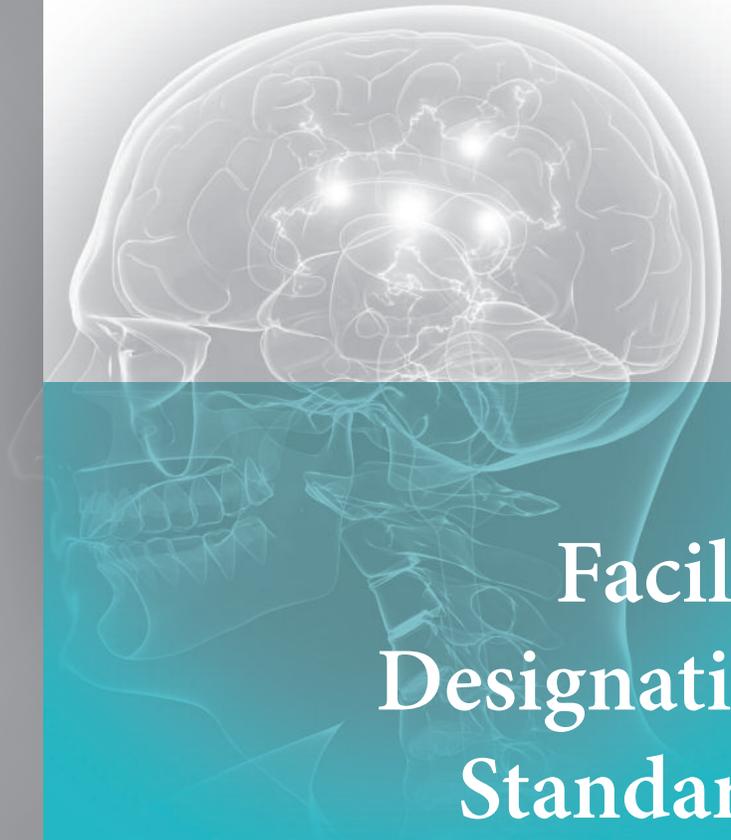


The Florida  
Department of Health

Brain &  
Spinal  
Cord  
Injury  
Program



Facility  
Designation  
Standards

Revised July 2013



## *Emergency Medical Services and Acute Care Standards*

**Brain and spinal cord injury research** has identified the first hours after trauma as being the most critical in terms of preserving and possibly restoring neurological function. Clinical experience points to the first two weeks following injury as the interval related to the highest incidence of mortality or morbidity, and the potential starting point for numerous systemic complications. The utilization of a multi-disciplinary evaluation and treatment approach results in a reduction of morbidity and mortality. Research findings lend significant support to the need for traumatic brain and/or spinal cord injury centers. These centers must provide the necessary personnel and material to properly evaluate and treat these injuries both promptly and comprehensively. Therefore, the care afforded the patient with a traumatic brain and/or spinal cord injury during this period must meet the highest performance standards.

Emergency Medical Services is charged with the management of the traumatically brain and spinal cord injured patient at the scene of injury. Thus, management begins at the scene and includes extrication, immobilization, and evaluation of central nervous system and systemic effects of trauma. It also includes proper “onsite care” designed to stabilize the patient’s condition and minimize secondary insults that may compromise the patient’s ultimate recovery. Emergency Medical Services is also charged with the formulation and organization of an efficient, safe and rapid transportation system that encompasses air and water, as well as land evacuation. These objectives will be accomplished through the development and implementation of standardized training programs for rescue and ambulance personnel.

Acute care, for this purpose, is defined as the time period beginning with the arrival of a new patient with a traumatic brain and/or spinal cord injury in an emergency department or acute care center until discharge from acute hospitalization.

### **Acute Care Standard Objectives**

- A. To design, maintain and promote a statewide system for the rescue, evaluation, treatment and care of patients with traumatic brain and/or spinal cord injuries.
- B. To establish criteria for designation of centers capable of delivering optimal evaluation, treatment and care to patients who sustain acute brain and/or spinal cord injuries.
- C. To promote and support an optimal continuum of care through coordination among pre-hospital emergency medical services, hospital emergency departments, and rehabilitation centers.
- D. To increase prompt recognition and initiation of proper emergency health care system response through information and education including public education on safety and prevention.
- E. To promote and support continuing education for emergency medical technicians (EMTs), paramedics, emergency department personnel, and other acute care staff.

## *Emergency Medical Services and Acute Care Standards*

### **A. Emergency Medical Services (EMS)**

1. A brain and/or spinal cord injury coordinator/EMS administrator(s) who facilitates a timely and orderly transfer of patients with acute traumatic brain and/or spinal cord injury to and from the hospital must be on staff. The coordinator(s) will facilitate and augment essential physician and treatment team communication.
2. Heliport landing facilities should be in proximity to the emergency department and shall meet FAA and DOT requirements.
3. The brain and/or spinal cord injury designated hospital shall maintain two-way radio communication with ambulances/rescue vehicles. This radio shall be compatible with the regional EMS and the Verified Trauma Center's standard communication system.
4. Medical/Surgical Plan of Care – A plan of care or clinical pathway must be developed and used as a guideline for the evaluation and treatment of patients with acute traumatic brain and/or spinal cord injury who have been accepted by the designated hospital for treatment. This plan of care shall be made available to all health providers in the catchment area. These providers shall be made aware that the hospital is an acute BSCIP Designated Facility and that all patients with a newly acquired traumatic brain and/or spinal cord injury should be transferred to the designated facility for optimal evaluation, treatment and care.

### **B. Hospital Requirements**

1. Must be accredited by the Joint Commission.
2. There should be a volume of admissions that meet the state definition of traumatic brain and/or spinal cord injury. A minimum of 50 new traumatic brain injury admissions and/or a minimum of 12 traumatic spinal cord injury admissions are required annually.

### **C. Hospital Support Capability**

1. The Emergency Department (ED) is staffed with a qualified and designated medical director. The ED physicians are trained in the evaluation, treatment and care of the critically ill patient with a traumatic brain and/or spinal cord injury, and at least one ED physician is present in the ED 24 hours a day.
2. There must be on staff a designated board certified/eligible neurosurgeon responsible for patients with acute traumatic brain and spinal cord injuries.
3. The following surgical specialists shall, in the case of associated multiple injuries, be available on call and promptly available:
  - a. Anesthesiologist
  - b. Cardiac surgeon
  - c. General surgeon

*Emergency Medical Services and Acute Care Standards*

---

- d. Interventional Radiologist
  - e. Maxillofacial surgeon
  - f. Obstetrics/gynecologic surgeon
  - g. Ophthalmic surgeon
  - h. Oral surgeon
  - i. Orthopedic surgeon
  - j. Otorhinolaryngologic surgeon
  - k. Pediatric surgeon
  - l. Reconstructive surgeon
  - m. Thoracic surgeon
  - n. Trauma surgeon
  - o. Urologic surgeon
  - p. Vascular surgeon
4. The following non-surgical specialists are on call, in person or via telemedicine, and are promptly available:
- a. Cardiologist
  - b. Gastroenterologist
  - c. Hematologist
  - d. Internal medicine
  - e. Nephrologist
  - f. Neurologist
  - g. Neuropsychologist, rehabilitation psychologist and/or clinical/health psychologist
  - h. Pathologist
  - i. Pediatrician
  - j. Physical medicine and rehabilitation
  - k. Psychiatrist
  - l. Pulmonologist
  - m. Radiologist
  - n. Urologist
5. The following facilities and personnel shall be available on call on a 24-hour basis:
- a. Blood bank services
  - b. Clinical lab
  - c. Counseling
  - d. EEG/or evoked potential monitoring
  - e. ICU with a minimum of four (4) beds available for patients with traumatic brain and/or spinal cord injury; staffed with personnel trained in brain and/or spinal cord injury acute care; and equipped with necessary equipment for brain and/or spinal cord injury care, including intracranial pressure (ICP) monitoring
  - f. Operating room
  - g. Pastoral care
  - h. Pharmacy

## *Emergency Medical Services and Acute Care Standards*

- i. Radiology department with CT and MRI scanning capability
  - j. Recovery room
  - k. Respiratory therapy
  - l. Social service
6. There should be a designated person responsible for ensuring new admissions are reported to the BSCIP Central Registry.
  7. The following services shall be available a minimum of five (5) days per week:
    - a. Nutritional support services
    - b. Occupational therapy
    - c. Physical therapy
    - d. Speech therapy
  8. Evaluation and treatment protocols for transfers of patients with traumatic brain and/or spinal cord injury should be established between BSCIP designated centers and other hospitals to promote optimal continuity of care. Telephone communication should be established between the physician in charge of the patient at the outlying hospital and the ED attending physician at the BSCIP designated facility regarding advice to supplement the treatment protocols and to effect transfers. The establishment of telemedicine links with referring hospitals is recommended.

### **D. Data Collection and Evaluation**

1. To ensure consistency in the initial evaluation and classification of traumatic spinal cord injuries and to ensure accurate communication between clinicians and investigators, hospitals must use the “Standard Neurological Classification of Spinal Cord Injury” developed by the American Spinal Injury Association (ASIA). (Spinal Cord Acute Care Designated Facilities only)
2. To ensure consistency in the initial evaluation and classification of brain injuries and to ensure accurate communication between clinicians and investigators, hospitals must use the Glasgow Coma Scale developed by G. Teasdale and B. Jennett. (Brain Injury Acute Care Designated Facilities only)
3. Program evaluation data should be collected on an ongoing basis and at least annually reviewed to include the following elements:
  - a. number of new brain and spinal cord injured patients
  - b. length of stay and disposition of these patients
  - c. monthly total quality management data with documented review of morbidity/mortality, referral where care is determined to require augmentation, and action plans for problem resolution where appropriate
4. The current guidelines titled “Guidelines for the Management of Severe Traumatic Brain Injury, 3rd Edition, A Joint Project of the Brain Trauma Foundation and the American Association of Neurosurgeons” are available and utilized for staff orientation and referenced per need. (Brain Injury Acute Care Designated Facilities only)

*Emergency Medical Services and Acute Care Standards*

---

- E.** Training – A comprehensive in-hospital training program must be available for the initial and continuing education of EMTs, paramedics, nurses, physicians, allied health personnel and other interested groups in the care of patients with acute brain and/or spinal cord injury.
- F.** The hospital shall actively collaborate with the State of Florida, Brain and Spinal Cord Injury Program as required.
- G.** All patients shall be referred to a brain and/or spinal cord injury support group and/or peer support groups in the local region. In areas where ongoing groups do not exist, the designated facility shall endeavor to sponsor them.
- H.** The hospital provides opportunities for interdisciplinary staff to participate in formal programs to educate the public in traumatic brain and/or spinal cord injury prevention, which may include the following components:
1. An ongoing community/public awareness program that may include the local media to target specific prevention concerns
  2. Regularly scheduled traumatic brain and/or spinal cord injury education programs with specific curriculum implemented in local elementary, middle or high schools:
    - a. Epidemiology of injury on both the local and national level
    - b. Consequences of injury (to include physical, cognitive, emotional, social and financial)
    - c. Prevention/safety techniques
    - d. First responder considerations
    - e. Traumatic brain and spinal cord injured survivor(s) to relate their personal experience with injury
    - f. Concussion and sports injuries
  3. A designated traumatic brain and/or spinal cord injury prevention coordinator
  4. Demonstrated involvement or collaboration with other organizations involved in prevention activities
  5. Active support of legislation that will influence public policy decisions to prevent traumatic brain and spinal cord injuries
  6. Familiarity with ongoing injury prevention programs and relevant local data regarding epidemiology of injury
  7. The ability to serve as an injury prevention resource for the community

## *Emergency Medical Services and Acute Care Standards*

### **Nursing Specific Standards:**

The standards for traumatic brain and spinal cord injury apply to nursing practice in the EMS and acute care settings. Emergency and acute traumatic brain and spinal cord injury nursing care is a direct service rendered to individuals, their families, and significant others. Such practice is based on specialized educational and clinical nursing experience.

Acute brain and spinal cord injury nursing care is patient-centered and goal-directed. Nurses are directly involved in evaluation and treatment of acute traumatic brain and spinal cord injuries. Additionally, nurses assist in teaching persons with traumatic brain or spinal cord injury and their family to maximize abilities, to minimize disabilities, and to prevent complications while dealing with the myriad of adjustments in their lifestyle.

- I.** Registered nurses providing treatment and care for persons with traumatic brain and/or spinal cord injuries will receive a minimum of eight contact hours every two years in subject matter relating to the treatment and care of persons with traumatic brain and/or spinal cord injuries.
- J.** Annual opportunities to participate in in-service training and/or formal continuing educational experiences for all nurses treating and caring for persons with traumatic brain and/or spinal cord injuries are provided to inform them about new knowledge, research and clinical procedures related to neuroscience practice, and pediatrics where appropriate. Documentation of participation is maintained.
- K.** Nurses shall have knowledge of and shall actively implement the Pressure Ulcer Prevention and Treatment Policy, which shall include all components identified in the Department of Health's Trauma Center Standards, Standard XIV - Acute Spinal Cord and Brain Injury Management Capability, Pamphlet 150-9 as incorporated by reference in Rule 64J-2.011, F.A.C.
- L.** The collection of data about the health status of patients is systematic and continuous. Program-determined data/information is obtained from patients and their family/social supports. Data/information obtained is both subjective and objective. The continuous collection of data should be documented in ongoing nursing care plans and/or nursing notes. This information is utilized for program evaluation.
- M.** Nurses shall assess patients for health status data to include, but not be limited to the following:
  - 1. Pre-injury biophysical status
  - 2. Pre-injury psycho/social status
  - 3. Current neurological status
  - 4. Developmental status
  - 5. Patient and family cultural needs
  - 6. Current pain assessment and management

## *Emergency Medical Services and Acute Care Standards*

---

7. Pressure ulcer development risk. The Braden Scoring Scale should be routinely used to identify patients at risk

**N.** Nursing diagnoses/problem identification includes the following:

1. A summary of the patient's neurological deficits, and functional capabilities/limitations
2. Diagnoses/problems are reconciled with the diagnoses of all other professionals caring for the patient

**O.** Nurses establish patient-centered goals/expected outcomes and plan interventions as appropriate. Goals/expected outcomes established should:

1. Include consistent participation of the patient and family/social support
2. Be individualized to each patient
3. Be congruent with other planned therapies
4. Be stated in realistic and measurable terms
5. Be designed to prevent secondary conditions

**P.** Nursing actions are planned to promote, maintain, and restore the patient's physical, emotional, social, and developmental health and should include, but not be limited to the following:

1. Physiological measures are planned to prevent or control specific patient problems and secondary conditions. These include, but are not limited to the following:
  - a. Skin integrity/pressure ulcer risk
  - b. Nutrition, hydration
  - c. Elimination - bladder, bowel progress
  - d. Respiratory, ventilatory functions
  - e. Circulatory status - prevention of venous stasis
  - f. Prevention or minimization of infection - respiratory, urinary and especially central nervous system
  - g. Musculoskeletal system - prevention of contractures, minimization of spasticity
  - h. Secondary insults to the nervous system
  - i. Spinal shock
  - j. Autonomic dysreflexia
  - k. Pain assessment/management
2. Psycho/social measures, as appropriate, are planned to prevent or control specific patient/family problems. These include, but are not limited to the following:
  - a. Emotional adjustment process
  - b. Loss of sensation, movement, bowel/bladder and sexual dysfunction

## *Emergency Medical Services and Acute Care Standards*

- c. Financial concerns
- d. Family participation in care
- e. Privacy needs
- f. Communication skills
- g. Behavioral problem recognition/management
- h. Altered mental status
- i. Developmental issues
- j. Community reintegration
- k. Cultural issues and needs

- Q.** Nursing interventions should be evidence-based and provide the most current, up-to-date, and effective approaches for the patient's condition. Nursing interventions:
1. Are consistent with the medical plan of care
  2. Provided in a safe, therapeutic environment
  3. Involve teaching/learning opportunities
  4. Utilize appropriate learning resources to expand the patient and/or family's knowledge about the nature of injury, therapeutic regimen and prevention of secondary complications
- R.** Nursing plans of care are continually reviewed and updated as a result of episodic evaluation and reassessment of patients' progress toward goals. New goals/expected outcomes and approaches are developed by nursing staff, in coordination with the interdisciplinary team and with input from patients' and family/social supports.
- S.** Discharge planning efforts, when appropriate, are implemented on admission to the acute care facility. Rehabilitation plans are established within seven days of admission.
- T.** Nursing staff work in conjunction with patients, families/social supports, other members of the health care team, and community agencies to facilitate acute care, rehabilitation, and discharge planning.
- U.** Nursing staff participate in the designated facility's injury prevention initiatives.

### **Psychology Specific Standards:**

The purpose of standards applicable to the acute treatment setting is to provide minimum clinical and programmatic practice guidelines to facilitate management of cognitive, behavioral and emotional reactions to traumatic injury, to facilitate provision of treatment and care by the acute medical team, to promote favorable outcomes from medical treatment, and optimize adaptive function in individuals with traumatic brain and/or spinal cord

## *Emergency Medical Services and Acute Care Standards*

injuries. Through evaluation, assessment, intervention, and education services provided within an acute care interdisciplinary team environment, psychologists focus upon positively impacting acute stress response, acute institutionalization, pain management during stressful medical procedures, and family/social support concerns as the patient and their family/social support system navigate the acute medical environment. The purposes of providing such services are to reinforce adaptive functional outcomes, to evaluate cognitive, emotional and behavioral factors affecting team treatment, and to facilitate effective decision-making in service of enhancing quality of life. Every effort is made to provide services to patients and families/social support where there are cultural and communication factors, e.g., language barriers, deafness, blindness, tracheostomy, etc.

### V. Staffing

1. There is, at minimum, one designated doctoral level licensed psychologist with expertise in traumatic brain and/or spinal cord injury identified as the psychologist with responsibility for acute brain and/or spinal cord injury service. Qualifications include a minimum of three (3) years experience working with individuals with traumatic brain and/or spinal cord injuries and ongoing professional education related to brain and/or spinal cord injury rehabilitation. Psychologists working with pediatric populations should have training, expertise and ongoing professional education in the area of pediatrics.
2. Qualified masters level clinicians with mental health credentials to provide clinical services to patients with traumatic brain and/or spinal cord injury may also be employed as staff in addition to doctoral level licensed psychologists. However, they must be under the direct supervision of a doctoral level licensed psychologist. The ratio of doctoral level psychologists to masters level clinicians should not exceed 1:2.
3. The number of psychologists and masters level clinicians on staff must be sufficient to provide the necessary clinical psychological services.

### W. Orientation and Training

1. Psychologists should demonstrate professional competencies or, at a minimum, be provided with an orientation of the brain and spinal cord injury components of the following disciplines:
  - a. Rehabilitation psychology, neuropsychology, clinical/health psychology, or clinical mental health counseling
  - b. Physical therapy
  - c. Occupational therapy
  - d. Nursing
  - e. Social work/case management
  - f. Speech/language pathology
  - g. Medical specialties, e.g., physical medicine and rehabilitation, neurology, etc.
  - h. Other disciplines, e.g., dietician/nutrition, pastoral care, etc.

## *Emergency Medical Services and Acute Care Standards*

---

2. Professional competencies and/or orientation should include the following:
  - a. Pathophysiology and functional neuroanatomy, including methodology for determining spinal cord injury level, completeness of spinal cord injury, and methodology for determining severity of cognitive and functional injuries
  - b. Neuropsychological/cognitive screening assessment instruments
  - c. Emotional and behavior assessment instruments
  - d. Developmental assessment
  - e. Substance abuse
  - f. Sexual functioning
  - g. Family/cultural factors
  - h. Activities of daily living and principles of care-giving
  - i. Relevant medical management
  - j. Goals and philosophies of the unit
  - k. Rehabilitation resources in the community
3. Psychologists and mental health clinicians must demonstrate ongoing professional education in the area of traumatic brain and/or spinal cord injury rehabilitation.
4. Psychologists and mental health clinicians working with pediatric patients must demonstrate ongoing professional education in the area of pediatric traumatic brain and/or spinal cord injury rehabilitation.

### **X. Clinical Procedures**

1. Evaluation - Initial evaluations must be completed within the first seventy-two hours of admission and integrated interdisciplinary treatment plans must be signed within the first four days of patient admission. Documentation should address the following, but not be limited to:
  - a. Pre-morbid cognitive, emotional and behavioral status, along with educational and vocational history
  - b. Cognitive/behavioral status of the patient
  - c. Emotional/behavioral status of the patient and family/social support system
  - d. Recommendations for optimizing acute care outcomes and rehabilitation potential
  - e. Identification of anticipated cognitive, emotional or behavioral problems that may influence follow-up treatment or care
2. Treatment Plans – Psychology treatment plans, including current psychological status, goals of treatment interventions to be provided, and response to initial treatment, must be developed after the initial evaluation and updated per contact and progress notes.
3. Formal Testing - The type and frequency of cognitive, emotional or other psychological testing should be provided as clinically warranted and appropriate for the acute care setting, or as approved for research purposes.

## *Emergency Medical Services and Acute Care Standards*

4. Treatment Interventions – Treatment interventions should be made available to acute patients with traumatic brain and/or spinal cord injuries and families/social support systems as deemed clinically appropriate.
  5. Discharge Summaries – There should be a psychology discharge summary for each patient. Discharge summaries should include the following:
    - a. Pre-morbid psychological, behavioral and educational/work status
    - b. Initial cognitive, emotional and behavioral status
    - c. Treatment intervention provided
    - d. Current cognitive, emotional and behavioral status
    - e. Status of family/social support system adjustment
    - f. Recommendations for post acute care
  6. Documentation - The following psychology-related documentation must be maintained within its own section in patient charts:
    - a. Initial clinical intake evaluation, addressing cognitive, emotional and behavioral issues
    - b. Results of any formal testing performed
    - c. Psychology treatment plan
    - d. Psychology service progress notes, including treatment plan updates
    - e. Discharge summary
- Y.** Interdisciplinary Collaboration - Psychology services must be provided as part of an integrated interdisciplinary team approach. Psychologists and/or mental health clinicians should be involved, when appropriate, with the following:
1. Team conference and rounds
  2. Participate in patient and family/social support conferences
  3. Consult with each discipline involved with the patient and family/social support system per need
  4. Liaison with psychiatry services when involved
- Z.** Psychologists are aware of the importance of traumatic brain and spinal cord injury prevention initiatives and assist the interdisciplinary rehabilitation team in these endeavors as appropriate/indicated.
- AA.** Psychologists should be involved in traumatic brain and spinal cord injury service related program and policy development.
- AB.** Psychologists should participate in program evaluation and quality assurance activities as appropriate/indicated.

## *Adult Brain and Spinal Cord Injury Inpatient Rehabilitation Center Standards*

**Rehabilitation refers to those treatment** and intervention processes occurring after injury that target optimization of an individual's functional recovery. This complex care is provided in a rehabilitation center capable of managing recent injury, comprehensive medical, physical, social, psychological and trauma-related problems and complications. Facility administration provides for designated traumatic brain and/or spinal cord injury beds and a comprehensively trained staff functioning within an interdisciplinary team treatment model. Services available should include physician specialists, physical, occupational, and speech therapy, specialized nursing, family support services, therapeutic recreation, psychological services and education of both patient and family. Collaboration with vocational rehabilitation agencies and/or the educational system may occur per need. Referrals to an inpatient rehabilitation center typically originate from acute medical centers, other comprehensive rehabilitation centers, long-term care facilities, or sub-acute rehabilitation programs. Early initiation of comprehensive rehabilitation has been documented to result in independence and improved functional outcomes for patients with traumatic brain and/or spinal cord injury. Effective rehabilitation also results in fewer medical complications. Coordination among acute care and other tertiary care centers ensures efficient and effective continuity of care. The rehabilitation process should also focus upon establishing a lifetime program of care in the community with monitoring, reevaluation, upgrading functional performance, and monitoring for potential complications after hospital discharge.

### **Inpatient Rehabilitation Standard Objectives**

- A. Promote the highest quality inpatient rehabilitation program possible to ensure an optimal level of independence for individuals with traumatic brain and/or spinal cord injuries.
- B. Promote and support a system of adult and pediatric inpatient rehabilitation centers with expertise in providing optimal comprehensive care for persons with traumatic brain and/or spinal cord injury and their families.
- C. Promote and support the provision of a continuum of care by developing an efficient referral pattern between system components with appropriate documentation of services.

### **Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation**

To be eligible for state designation, a facility must demonstrate compliance with applicable standards established by the BSCIP. In addition, an inpatient rehabilitation center must be accredited by CARF as a Comprehensive Integrated Inpatient Rehabilitation Program, with accreditation as a Brain Injury Specialty Program and/or Spinal Cord System of Care. Facilities that are CARF accredited as a Comprehensive Integrated Inpatient Rehabilitation Program, but do not have accreditation in one or both of the required specialty programs, may become a BSCIP designated facility by demonstrating they are in the process of applying for accreditation in one or both of the required specialty programs. These facilities must achieve CARF accreditation in one or both specialty areas prior to the next BSCIP scheduled survey of their facility.

## *Adult Brain and Spinal Cord Injury Inpatient Rehabilitation Center Standards*

---

Facilities who choose to discontinue or fail to maintain CARF accreditation as a Comprehensive Integrated Inpatient Rehabilitation Program with accreditation in at least one of the specialty programs must notify the Brain and Spinal Cord Injury Program, as they will no longer be eligible for designation as a Brain and Spinal Cord Injury Program Designated Facility.

### **Fully CARF Accredited Facilities - Abbreviated Surveys**

Facilities that are CARF accredited as a Comprehensive Integrated Inpatient Rehabilitation Program, with accreditation as a Brain Injury Specialty Program and/or Spinal Cord System of Care are eligible for abbreviated surveys when reapplying for designation after completing a comprehensive survey and receiving BSCIP designation for a three-year period. Facilities that have received provisional status are not eligible for an abbreviated survey until they have been designated for a full three-year period.

### **Standards for Abbreviated and Comprehensive Surveys**

The following standards must be met by all inpatient rehabilitation centers, including those that have CARF specialty accreditation in brain and/or spinal cord injury:

- A.** The licensed rehabilitation center shall be accredited by CARF as a Comprehensive Integrated Inpatient Rehabilitation Program, with accreditation as a Brain Injury Specialty Program and/or Spinal Cord System of Care. CARF accreditation in other specialty program areas, including Vocational Services is encouraged.
- B.** There should be a volume of admissions that meet the state definition of traumatic brain and/or spinal cord injury. A minimum of 30 new traumatic brain injury admissions and/or a minimum of 40 spinal cord injury admissions are required annually. For inpatient spinal cord injury rehabilitation centers, up to 50 percent may include patients with non-traumatic paralysis resulting from acute vascular complications, iatrogenic causes, or other neuromuscular diseases.
- C.** Brain and spinal cord injury rehabilitation centers are required to have a minimum of 10 beds specifically designated for the rehabilitation of persons with traumatic brain and/or spinal cord injury, including availability of private rooms for individuals demonstrating medical and/or behavioral needs. Provisions should exist for ensuring a safe and secure environment, including the provision of close supervision as needed, consistent with the unique behavioral and cognitive limitations of the population.
- D.** The rehabilitation center shall provide a multipurpose group room for social, leisure/recreational, vocational, educational, communal dining and other group meetings as appropriate.
- E.** There should be a designated person responsible for ensuring that new admissions are reported to the BSCIP Central Registry.

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

- F.** All rehabilitation centers are required to subscribe to the Uniform Data System/Functional Independence Measure (FIM) data collection system or a similar data system that allows for submitted data to be integrated with the UDS/FIM data system.
- G.** The rehabilitation center must have policy and procedures to address cognitive capacity and legal competency issues.
- H.** The rehabilitation center shall evaluate patient cognitive-behavioral performance and make recommendations regarding driving.
- I.** The rehabilitation center shall utilize and integrate educational information developed by BSCIP, the Florida Spinal Cord Injury Resource Center and the Brain Injury Association of Florida.
- J.** The rehabilitation center provides opportunities for interdisciplinary staff to participate in programs to educate the public regarding traumatic brain and/or spinal cord injury prevention and should include the following components:
  - 1. Promotion of health through ongoing community/public awareness programs that may include the local media to target specific prevention concerns
  - 2. Regularly scheduled traumatic brain and/or spinal cord injury programs with specific curriculum implemented in local elementary, middle or high schools:
    - a. Epidemiology of injury on both the local and national level
    - b. Consequences of injury (to include physical, cognitive, emotional, social and financial)
    - c. Prevention techniques
    - d. First responder considerations
    - e. Traumatic brain and/or spinal cord injured survivors to relate their personal experience with injury
    - f. Concussion and sports injuries
  - 3. A designated brain and/or spinal cord injury prevention coordinator
  - 4. Demonstrated collaboration with other organizations involved in prevention activities
  - 5. Active support of legislation that will influence public policy decisions to prevent traumatic brain and spinal cord injuries
  - 6. Familiarity with ongoing injury prevention programs and relevant local data regarding epidemiology of injury
  - 7. A commitment to serve as an injury prevention resource for the community

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

- K.** The rehabilitation center's brain injury and/or spinal cord injury programs act as a resource for other similar programs regarding:
1. Evidence-based practice
  2. Sharing of best practice models
  3. Outreach, training, and support
- L.** The rehabilitation center shall actively collaborate with the State of Florida, Brain and Spinal Cord Injury Program as required.
- M.** There shall be formalized discharge/transition plans provided to patients and/or families that address, but are not limited to the following:
1. Financial issues – establish a process of ongoing contact with third party payors and relevant public and community agencies to ensure continuity of care
  2. Follow-up appointments
  3. Funding availability – access to benefits and other systems, such as education, vocational rehabilitation, social security, and worker's compensation
  4. Meaningful everyday routines – the level of understanding of the family/support system regarding the current status of the patient
  5. Medication education and activity restrictions
  6. Nutrition/Diet
  7. Provision of and instruction in the use of durable medical equipment
  8. Service availability – provide information regarding available options for follow-up care, community services and/or alternative programs
- N.** To ensure a smooth transition back into the community, the rehabilitation center must be able to demonstrate their referral processes to:
1. Designated licensed transitional living facilities
  2. Accredited vocational services programs
  3. Other appropriate community-based programs
- O.** The rehabilitation center has access to and utilizes local, regional, or national organizations or networks when necessary to facilitate specialized care of individuals with traumatic brain and/or spinal cord injury.

## *Adult Brain and Spinal Cord Injury Inpatient Rehabilitation Center Standards*

---

### **Nursing Specific Standards:**

The standards for brain and spinal cord injury apply to nursing practice in the inpatient rehabilitation setting. Inpatient rehabilitation brain and spinal cord injury nursing care is a direct service rendered to individuals, their families, and significant others. Such practice is based on specialized educational and clinical nursing experience.

#### **P. Staffing**

1. The rehabilitation center shall provide care which is supervised 24 hours per day by a registered nurse skilled in the care of patients with traumatic brain and/or spinal cord injuries. The nurse will be a Certified Rehabilitation Registered Nurse (CRRN) or will attend and document at least five (5) continuing education unit (CEU) hours a year in rehabilitation nursing. Attainment of the CRRN is strongly encouraged.
2. The nursing care of each patient shall be directed by a registered nurse skilled in traumatic brain and/or spinal cord injury nursing. Each nurse must document five (5) CEUs in the first year of employment and annually thereafter in the specialty of brain injury and/or spinal cord Injury.
3. The rehabilitation nurse shall participate as a member of the interdisciplinary team as evidenced by documented participation in:
  - a. Rehabilitation committees
  - b. Interdisciplinary conferences and meetings
  - c. Interdisciplinary therapeutic activities such as patient group sessions

### **Psychology Specific Standards**

The Psychology Standards provide minimum clinical practice guidelines supporting provision of high quality psychological services within the comprehensive inpatient rehabilitation program setting to patients and families/social support systems. These carefully planned evaluation, assessment and intervention services are intended to optimize adaptive cognitive, emotional, behavioral and physical function toward the goal of achieving independence and quality of life. Psychological services are provided within the framework of the interdisciplinary rehabilitation team.

#### **Q. Staffing**

1. There is, at minimum, one designated doctoral level licensed psychologist with expertise in traumatic brain and/or spinal cord injury identified as the psychologist with responsibility for the brain and/or spinal cord injury service. Qualifications include a minimum of three (3) years experience working with individuals with traumatic brain and/or spinal cord injuries and documentation of ongoing professional education related to traumatic brain and/or spinal cord injury rehabilitation. Psychologists working with pediatric populations should have training, expertise and documentation of ongoing professional education in the area of pediatrics.

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

**R.** Orientation and Training

1. Psychologists and mental health clinicians must demonstrate ongoing professional education in the area of traumatic brain and/or spinal cord injury rehabilitation.
2. Psychologists and mental health clinicians working with pediatric patients must demonstrate ongoing professional education in the area of pediatric traumatic brain and/or spinal cord injury rehabilitation.

**S.** Psychologists are aware of the importance of brain and spinal cord injury prevention initiatives and assist the interdisciplinary rehabilitation team in these endeavors as appropriate/indicated.

**T.** Psychologists should be involved in traumatic brain and spinal cord injury service related program and policy development.

**U.** Psychologists should participate in program evaluation and quality assurance activities as appropriate/indicated.

**Additional Standards for Comprehensive Surveys**

In addition to the previous standards, the following standards must be met by facilities that are not eligible for an abbreviated survey:

- V.** The rehabilitation center shall have the capability of safely transporting patients who use wheelchairs. The emphasis of transportation utilization should be for recreational, social activities, and/or medical appointments.
- W.** All rehabilitation centers are required to collect performance improvement data.
- X.** The rehabilitation center must have a formalized agreement with, or be part of, an acute care hospital within its catchment area.
- Y.** Each rehabilitation center will make available to referring facilities in their catchment area, staff with specialized training in evaluating patients with traumatic brain and/or spinal cord injuries. These admissions liaison staff will provide recommendations for inpatient rehabilitation care and shall provide ongoing clinical consultation upon request.
- Z.** There should be staff designated to coordinate traumatic brain injury and spinal cord injury rehabilitation care whose responsibilities include, but are not limited to:
1. Facilitating referrals and admissions to the rehabilitation center, as well as transfers to and from acute care hospitals

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

2. Dissemination of information to related agencies and institutions
  3. Liaison with state agencies and insurance companies
  4. Coordinating disaster relief with county and state emergency management officials
- AA.** The rehabilitation center's medical director shall be a physician who meets CARF criteria for training, knowledge and experience in the rehabilitation of patients admitted to the specific specialty programs; that is, specialized training and experience in traumatic brain injury rehabilitation for designated brain injury rehabilitation centers and specialized training and experience in traumatic spinal cord injury rehabilitation for designated spinal cord injury rehabilitation centers.
- AB.** Team members from the professional disciplines with training, experience, and expertise as described in the CARF brain and spinal cord injury standards must be included as staff of the rehabilitation center. In addition, medical consultative services must be available. These include, but are not limited to:
1. General surgery
  2. Internal medicine and other subspecialties
  3. Neurology
  4. Neurosurgery
  5. Obstetrics/Gynecology
  6. Ophthalmology
  7. Orthopedic surgery
  8. Otorhinolaryngology
  9. Pediatrics
  10. Physical medicine and rehabilitation
  11. Psychiatry
  12. Pulmonology
  13. Radiology
  14. Reconstructive surgery
  15. Rehabilitation Psychology
  16. Urology
  17. Vascular surgery
- AC.** The rehabilitation center should have or be able to demonstrate provision for the following services:
1. Audiology
  2. Dentistry
  3. Dietetic/nutrition
  4. Education, e.g., local school boards, home bound teachers, etc.
  5. Orthotics/prosthetics
  6. Pharmacy
  7. Respiratory therapy
  8. Vocational services

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

- AD.** Diagnostic services should be available or readily accessible on a referral basis including:
1. Electro-diagnostic services, as relevant
  2. Laboratory and other diagnostic services
  3. Radiological imaging services, as relevant
  4. Urodynamics
- AE.** A written statement shall be kept defining the program. It shall include at minimum the following:
1. A summary of the overall program and its components
  2. The admission criteria
  3. The discharge criteria
  4. The assessment procedures
  5. The staffing patterns
  6. Quality assurance procedures
  7. Program evaluation and performance improvement procedures
  8. Post-discharge follow-up, referral procedures and linkages to community resources
- AF.** Initial evaluations must be completed within the first seventy-two hours and integrated interdisciplinary treatment plans must be signed within the first four days of patient admission. Documentation should address the following, but not be limited to:
1. Activities of daily living and functional mobility skills
  2. Behavioral status
  3. Cognitive status
  4. Communication capacity
  5. Community reintegration
  6. Education and/or vocational employment potential
  7. Environmental modification
  8. Family Counseling/Education
  9. Health and nutrition
  10. Medical status
  11. Perceptual capacity
  12. Psychosocial status
  13. Recreation and leisure time skills
  14. Sensorimotor capacity, including gross and fine motor strength and control, sensation, balance, joint range of motion, mobility and function
  15. Sexuality
  16. Swallowing
- AG.** Integrated interdisciplinary treatment plans should be continually revised and updated weekly based on patients' status.

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

- AH.** The rehabilitation center shall identify the individual(s) responsible for coordination of follow-up plans of patients.
- AI.** There shall be a mechanism in place to manage patients who abuse alcohol and/or drugs.
- AJ.** The rehabilitation center defines its interventions in the following areas:
1. Identifying and reducing the risk factors for recurrent traumatic brain and/or spinal cord injury
  2. Facilitating psychological and social coping and adaptation skills
  3. Facilitating community reintegration and participation in life roles that contribute to society
- AK.** The rehabilitation center provides information and referral to patients/families as appropriate to the following:
1. Behavioral health programs
  2. Clinical research centers
  3. Consumer advocacy organizations
  4. Independent living centers
  5. Transitional and/or residential treatment centers
- AL.** The rehabilitation center provides opportunities to try new equipment and technology and provides prescriptions/recommendations for the following, as appropriate:
1. Assistive technology
  2. Durable medical equipment
  3. Environmental modification
  4. Rehabilitation engineering
  5. Wheel chairs:
    - a. Modification
    - b. Ordering
    - c. Seating
    - d. Training in community settings
- AM.** The rehabilitation center must have policy and procedures to address management of behavior issues of patients with traumatic brain and/or spinal cord injuries. The rehabilitation center must be able to provide evidence of staff training and competencies in behavior management techniques.

## *Adult Brain and Spinal Cord Injury Inpatient Rehabilitation Center Standards*

---

### **AN.** Interdisciplinary staff should:

1. Be involved in the rehabilitation center's planning of new construction or reconstruction of areas where patients with traumatic brain and/or spinal cord injuries will be placed.
2. Participate in the rehabilitation center's disaster preparedness process.

### **Comprehensive Nursing Specific Standards:**

#### **AO.** Staffing

1. The rehabilitation center shall provide brain and/or spinal cord injury nurses in adequate numbers, as based upon a system used to identify patient acuity and nursing care needs. Numbers of staff and skill mix are determined by an established system within the center.
2. Rehabilitation centers serving pediatric rehabilitation programs will employ/contract with nurses knowledgeable and experienced in the care of children with traumatic brain or spinal cord injury, and their family.

#### **AP.** Training and Education

1. The rehabilitation center shall provide a formal orientation program for all nursing staff caring for patients with traumatic brain and/or spinal cord injuries. This orientation program shall address specifics of care, including, but not limited to:
  - a. Human dignity and emotional needs
  - b. Stages of human development
  - c. Effects of immobility
  - d. Bowel and bladder management
  - e. Skin care
  - f. Human sexuality
  - g. Complications and secondary conditions
  - h. Cognitive levels
  - i. Emergency interventions and management of acute problems
  - j. Behavior management
  - k. Safety
  - l. Neurological assessment
  - m. Family/patient education
  - n. Effective staff/family communication
  - o. Psychological adjustment
  - p. Autonomic Dysreflexia
  - q. Recreation and leisure activities
  - r. Stress management
  - s. Family dynamics including signs and symptoms of dysfunction, coping styles and appropriate intervention

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

2. The rehabilitation center provides in-service education at least monthly. These sessions may be interdisciplinary and may be taught by various members of the rehabilitation team. In-service specific to traumatic brain injury or spinal cord injury should be presented at least quarterly.
3. There shall be traumatic brain and spinal cord injury resource materials available to the nursing staff. These resources should include professional journals, books, articles, and audiovisual materials.
4. There is evidence of cross training in rehabilitation of nurses from other units or areas within the center being utilized.
5. The nurses' performance competencies shall be evaluated at least annually and documented.
6. There shall be policies and procedures specific to brain and/or spinal cord injury nursing care, including, but not limited to:
  - a. Bowel and bladder management
  - b. Orthotic and prosthetic care (i.e. halo)
  - c. Neurological assessment
  - d. Skin care maintenance, prevention and prediction of pressure ulcers and treatment
  - e. Body mechanics and transfer techniques
  - f. Turning and positioning
  - g. Provisions of emergency care
  - h. Safety
  - i. Autonomic Dysreflexia
  - j. Management of the agitated/aggressive patient

**AQ.** Nursing Process

1. The brain and spinal cord injury rehabilitation nurse shall participate with the interdisciplinary team and other agencies in assessing, planning, implementing and evaluating the patient's care, the rehabilitation program, and other related activities. The pre-admission screening process/assessment shall involve a registered nurse.
2. The brain or spinal cord injury rehabilitation nurse collects data about the health status of the individual and family unit that is systematic, comprehensive and accurate.
3. The integrated treatment plan includes a nursing assessment which includes:
  - a. Biophysical factors
  - b. Psychosocial status
  - c. Age appropriateness
  - d. Cognitive-communicative status

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

- e. Functional skills
- f. Vocational-education status
- g. Comfort measures
- h. Cultural factors
- i. Support systems
- j. Identified patient/family goals
- k. Other associated factors
- l. Nursing diagnosis or problem list

**AR.** Planning

1. There is evidence of patient/family involvement in the RN-initiated plans of care.
2. The plan of care reflects the nursing diagnosis or problems and goals expressed in measurable terms with expected achievement dates.
3. The plan reflects the following:
  - a. Bowel and bladder needs
  - b. Skin care maintenance, prevention and prediction of pressure ulcers and treatment
  - c. Patient/family education
  - d. Promotion of self-care
  - e. Psychosocial/sexual concerns
  - f. Early discharge planning
  - g. Cognitive, perceptual deficits
4. The plan is initiated within 24 hours of admission.
5. There is documentation that the plan is reviewed and updated at least weekly.

**AS.** Intervention

1. The brain and spinal cord injury rehabilitation nurse shall implement nursing actions based on the plan of care to prevent complications, and promote, maintain, or restore realistic optimal function. Nursing actions are consistent with the total rehabilitation program to achieve patient and family goals.
2. Interventions shall be specific to the plan of care and emphasize actions in the following areas, but not be limited to:
  - a. Promotion of self-care
  - b. Promotion of appropriate developmental status
  - c. Maintenance of body function
  - d. Prevention of complications
  - e. Management of emergencies

## *Adult Brain and Spinal Cord Injury Inpatient Rehabilitation Center Standards*

---

- f. Management of behavioral changes
  - g. Coping and adjustment
  - h. Environmental safety
  - i. Discharge planning
3. The brain and spinal cord injury rehabilitation nurse shall adjust the teaching program as needed to accommodate cultural and educational differences of the individual patient and family.
  4. There shall be documentation of the teaching done, the methodology used, and the measurement of learning/recall.

### **AT.** Evaluation

1. The brain and spinal cord injury rehabilitation nurse shall evaluate the effectiveness of care planning and document patient progress at least daily.
2. There shall be a mechanism for patients and/or families to participate in evaluating nursing care.

### **AU.** Program Development/Research

1. The rehabilitation center promotes opportunities for schools of nursing to incorporate clinical rehabilitation nursing in their curricula by providing a practice setting for students.
2. The rehabilitation center shall provide opportunities for the brain and spinal cord injury rehabilitation nurse to participate in related research.
3. Rehabilitation nurse(s) shall have input into major program changes which may impact on brain and spinal cord injury care.

### **AV.** Environmental Safety - There shall be adequate equipment, including patient lifting equipment and emergency supplies available for the nursing staff.

### **Comprehensive Psychology Specific Standards**

#### **AW.** Staffing

1. Qualified masters level clinicians with mental health credentials to provide clinical services to patients with brain and/or spinal cord injury may also be employed as staff in addition to doctoral level licensed psychologists. However, they must be under the direct supervision of a doctoral level licensed psychologist. The ratio of doctoral level psychologists to masters level clinicians should not exceed 1:2.
2. The number of psychologists and masters level clinicians on staff must be sufficient to provide the necessary clinical psychological services.

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

**AX.** Orientation and Training

1. Psychologists should demonstrate professional competencies or, at a minimum, be provided with an orientation of the brain and spinal cord injury components of the following disciplines:
  - a. Rehabilitation psychology, neuropsychology, clinical/health psychology or clinical mental health counseling
  - b. Physical therapy
  - c. Occupational therapy
  - d. Nursing
  - e. Social work/case management
  - f. Speech/language pathology
  - g. Therapeutic recreation
  - h. Vocational services
  - i. Medical specialties, e.g., physical medicine and rehabilitation, neurology, etc.
  - j. Other disciplines, e.g., dietician/nutrition, pastoral care, etc.
  
2. Professional competencies and/or orientation should include, but not be limited to the following:
  - a. Brain-behavior relationships
  - b. Functional sequelae of brain and/or spinal cord injury
  - c. Cognitive assessment
  - d. Emotional and behavioral assessment
  - e. Developmental assessment
  - f. Neuropsychological/cognitive screening assessment instruments
  - g. Emotional and behavior assessment instruments
  - h. Emotional adjustment and coping strategies, including evidence-based practices
  - i. Assessment and management of agitation, confusional states, post-operative or medication mediated sedation effects, and depression/anxiety
  - j. Neuro-diagnostic tests (e.g., relevant imaging technologies, neurological examination related to cognitive and neuromuscular function)
  - k. Substance abuse
  - l. Sexual functioning
  - m. Family/cultural factors
  - n. Activities of daily living and principles of care-giving
  - o. Relevant medical management
  - p. Rehabilitation resources in the community
  - q. Medical records
  - r. Rehabilitation program philosophy and goals
  - s. Overview of the rehabilitation process, and the continuum of care in the context of the center

## *Adult Brain and Spinal Cord Injury Inpatient Rehabilitation Center Standards*

---

3. Psychologists and mental health clinicians must demonstrate ongoing professional education in the area of traumatic brain and/or spinal cord injury rehabilitation.
4. Psychologists and mental health clinicians working with pediatric patients must demonstrate ongoing professional education in the area of pediatric traumatic brain and/or spinal cord injury rehabilitation.

### **AY.** Clinical Procedures

1. Evaluation - Initial evaluations must be completed within the first forty-eight hours and integrated interdisciplinary treatment plans must be signed within the first four days of patient admission. Documentation should address the following, but not be limited to:
  - a. Pre-morbid cognitive, emotional and behavioral status, along with educational and vocational history
  - b. Cognitive/behavioral status of the patient
  - c. Emotional/behavioral status of the patient and family/social support system
  - d. Recommendations for optimizing rehabilitation outcomes
  - e. Identification of anticipated cognitive, emotional or behavioral problems that may influence follow-up treatment or care
2. Assessment – Testing needs will be determined by the licensed psychologist. The psychologist will ensure the protection of raw test data in conjunction with medical records. Test results will be included in the patient's medical record. The assessment may include, but is not limited to:
  - a. Cognitive/mental status screening
  - b. Neuropsychological testing
  - c. Intelligence testing
  - d. Emotional status testing
  - e. Consideration of vocational needs
  - f. Educational testing
  - g. Approved testing related to research projects
3. Treatment Plan – A psychology treatment plan, including current emotional, behavioral and cognitive status, goals of treatment, interventions being provided and response to treatment intervention, should be developed after the initial assessment. The plan is updated per contact in progress notes and included in the integrated team treatment plan.

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

4. Treatment Interventions – Treatment interventions available to brain and/or spinal cord injured patients may include, but are not limited to the following:
  - a. Individual psychotherapy
  - b. Group psychotherapy
  - c. Family support
  - d. Behavioral management
  - e. Cognitive remediation
  - f. Sexual counseling
  - g. Marital counseling related to rehabilitation goals
  - h. Educational/vocational counseling
  - i. Pain management
  - j. Assertiveness/social skills training
  - k. Stress management
  - l. Play therapy
  - m. Parent training
  - n. Anger management
  - o. Neuropsychological coaching/cognitive rehabilitation
  - p. Rehabilitation education
  
5. Discharge Summary – There is a psychology discharge summary for each patient that includes:
  - a. Pre-morbid psychological, behavioral and educational/work status
  - b. Initial cognitive, emotional and behavioral status
  - c. Treatment intervention provided
  - d. Response to treatment
  - e. Current cognitive, emotional and behavioral status
  - f. Functional capabilities
  - g. Estimated functional potential and discharge disposition
  - h. Recommendations for post inpatient rehabilitation care
  
6. Documentation - The following psychology-related documentation must be maintained within its own section in patient charts:
  - a. Initial clinical intake evaluation addressing cognitive, emotional and behavioral issues
  - b. Results of any formal assessment performed
  - c. Psychology treatment plan and updates
  - d. Psychology service progress notes
  - e. Discharge summary

*Adult Brain and Spinal Cord Injury  
Inpatient Rehabilitation Center Standards*

---

- AZ.** Interdisciplinary Collaboration - Psychology services must be provided as part of an integrated interdisciplinary team approach. Psychologists and/or mental health clinicians should be involved, when appropriate, with the following:
1. Team conference and rounds
  2. Participate in patient and family/social support conferences
  3. Consult with each discipline involved with the patient and family/social support system
  4. Liaison with psychiatry services
  5. Family education and support groups
  6. Provision of continuing professional education (in-house or external to the center) concerning psychological aspects of rehabilitating individuals with brain and/or spinal cord injuries
  7. Acute care/trauma services

## *Adult Brain Injury Outpatient Rehabilitation Center Standards*

**Rehabilitation refers to those treatment** and intervention processes occurring after injury that target optimization of an individual's functional recovery. This complex care is provided in a rehabilitation center capable of managing recent injury, comprehensive medical, physical, social, psychological and trauma-related problems and complications. Facility administration provides for designated traumatic brain injury beds and a comprehensively trained staff functioning within an interdisciplinary team treatment model. Services available should include physician specialists, physical, occupational, and speech therapy, specialized nursing, family support services, therapeutic recreation, psychological services and education of both patient and family. Collaboration with vocational rehabilitation agencies and/or the educational system may occur per need. Referrals to an outpatient rehabilitation center typically originate from acute medical centers, other comprehensive rehabilitation centers, long-term care facilities, or sub-acute rehabilitation programs. Early initiation of comprehensive rehabilitation has been documented to result in independence and improved functional outcomes for patients with traumatic brain injury. Effective rehabilitation also results in fewer medical complications. Coordination among acute care and other tertiary care centers ensures efficient and effective continuity of care. The rehabilitation process should also focus upon establishing a lifetime program of care in the community with monitoring, reevaluation, upgrading functional performance, and monitoring for potential complications after hospital discharge.

### **Outpatient Rehabilitation Standard Objectives**

- A. Promote the highest quality outpatient rehabilitation program possible to ensure an optimal level of independence for individuals with traumatic brain injuries.
- B. Promote and support a system of adult and pediatric outpatient rehabilitation centers with expertise in providing optimal comprehensive care for persons with traumatic brain and/or spinal cord injury and their families.
- C. Promote and support the provision of a continuum of care by developing an efficient referral pattern between system components with appropriate documentation of services.

### **Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation**

To be eligible for state designation, an outpatient rehabilitation center must demonstrate compliance with the following standards established by the BSCIP. In addition, an outpatient rehabilitation center must be accredited by CARF as an Outpatient Medical Rehabilitation Program, with accreditation as a Brain Injury Specialty Program. Facilities that are CARF accredited as an Outpatient Medical Rehabilitation Program, but do not have accreditation as a Brain Injury Specialty Program, may become a BSCIP designated facility by demonstrating they are in the process of applying for this specialty accreditation. Facilities must achieve CARF accreditation as a Brain Injury Specialty Program prior to the next BSCIP scheduled survey of their facility.

## *Adult Brain Injury Outpatient Rehabilitation Center Standards*

---

Facilities who choose to discontinue or fail to maintain CARF accreditation as an Outpatient Medical Rehabilitation Program, with accreditation as a Brain Injury Specialty Program must notify the Brain and Spinal Cord Injury Program, as they will no longer be eligible for designation as a Brain and Spinal Cord Injury Program Designated Facility.

- A.** The licensed rehabilitation center shall be accredited by CARF as an Outpatient Medical Rehabilitation Program, with accreditation as a Brain Injury Specialty Program. CARF accreditation in other specialty program areas, including Vocational Services is encouraged.
  
- B.** There should be a volume of admissions that meet the state definition sufficient to support a comprehensive, categorically designated program of services. A minimum of 10 patients ongoing per year or 100 outpatient contact hours per week is required to maintain a viable outpatient rehabilitation Brain Injury program.
  
- C.** Standards for admission to the Brain Injury Outpatient Rehabilitation Center should include the following:
  - 1. The patient is traumatically brain injured
  
  - 2. The patient is in need of therapeutic intervention for the improvement of physical, cognitive, communicative, behavioral, psychological, social and/or emotional functioning
  
  - 3. There should be indication that the patient can benefit from rehabilitation efforts
  
  - 4. The patient should be manageable within the staffing and environmental limitations of the center
  
  - 5. The patient should have no major medical or psychological conditions that preclude attendance and/or participation in the program
  
  - 6. The center should make formal requests for pertinent medical, educational and vocational records as appropriate
  
- D.** The Brain Injury Outpatient Rehabilitation Center should offer, either by the program or through consultation arrangements, the following as appropriate:
  - 1. Physical restoration services including physical therapy and occupation therapy
  
  - 2. Speech/language pathology services
  
  - 3. Cognitive remediation
  
  - 4. Development of activities of daily independence
  
  - 5. Psychological adjustment

*Adult Brain Injury Outpatient Rehabilitation Center Standards*

---

6. Development of appropriate social interaction skills
  7. Behavioral management abilities or contingencies
  8. Pre-vocational and/or vocational skills development
  9. Academic skills restoration
  10. Development of recreation and leisure activities
  11. Use of community resources
  12. Patient screening and evaluation procedures
  13. Development of an individualized treatment plan for each patient outlining goals and methods to achieve each goal
  14. Anticipated time frames for the accomplishment of patient specific goals
  15. Time intervals at which treatment of service outcomes will be reviewed
  16. Liaison and coordination with community agencies in the patient's local or home community
  17. Training and supervision to all staff on a continuing basis
  18. Referral to physician for review of medical needs
  19. Neuropsychological/psychological assessments
- E.** A written statement shall be kept defining the program. It shall include at minimum the following:
1. A summary of the overall program and its components
  2. The admission criteria
  3. The discharge criteria
  4. The assessment procedures
  5. The staffing patterns
  6. Quality assurance procedures
  7. Program evaluation and performance improvement procedures
  8. Post-discharge follow-up, referral procedures and linkages to community resources

*Adult Brain Injury Outpatient Rehabilitation Center Standards*

---

- F.** There shall be formalized interdisciplinary evaluations completed on each patient. Evaluations must be completed at minimum at the beginning and at the end of the treatment. Initial evaluations will be aimed at delineating the functional deficits that the patient has and at establishing treatment goals for each patient and family and must be completed by the entire interdisciplinary team within two weeks of admission to the program. It is expected that ongoing monitoring of progress be provided throughout the course of treatment. Final evaluations will be utilized for determining outcome and to make recommendations for further treatment/management and must be completed within one month of discharge from the program.
- G.** After the initial evaluation of the patient and family, there shall be a written plan developed for his/her treatment including treatment objectives, and guidelines for discharge or advancement to another program component. The treatment plan should:
1. Be functional, measurable and objective
  2. Focus on maximizing independent function and participation of the patient within their environment
  3. Be based on the review of referral information and evaluation of the patient's specific needs
  4. Be reviewed as per regulatory guidelines to assess progress, methods and goals
  5. Be coordinated with other treatment provided to the individual by community agencies
  6. Provide for mechanisms of family involvement
  7. Provide for community reintegration services
  8. Indicate the expected frequency and duration of the treatment
  9. Not encourage or support unrealistic expectations
- H.** The program should establish policies and procedures that address the following:
1. Medical emergencies
  2. Exchange of pertinent medical information
  3. Brain injury specific complications
  4. Medical contraindication
  5. Medication review
- I.** Appropriate processes should be in place to refer patients to other disciplines, specialists, and community, state and other agencies.

*Adult Brain Injury Outpatient Rehabilitation Center Standards*

---

- J.** The center must be able to demonstrate their referral process to an accredited Vocational Services program in the community.
- K.** The center should maintain a standard for collection of quantifiable data substantiation of current treatment status and progress review. All disciplines should provide continuous measurable data to be included in all verbal and written progress reports.
- L.** Case conferences should be held a minimum of once per month. All treatment parties should be present or represented for the purpose of reviewing progress and the interdisciplinary treatment plan. Formal conference summaries should be included in the case record containing quantified data, progress, intended treatment and discharge status.
- M.** Families of patients shall be made aware of treatment progress and goals. Treatment efforts shall be directed at integrating changes into the patient's family setting as appropriate.
- N.** There shall be a system of documenting each patient's contact.
- O.** Appropriate staff should be assigned to facilitate program coordination, community interaction, and family interaction.
- P.** There shall be an appropriate level of qualified staff to ensure that professional personnel can adequately maintain the treatment planning and measurement of treatment effect.
- Q.** Professional personnel must maintain one-to-one treatment contact with each patient on a frequency sufficient to allow for professional oversight and input to the treatment process.
- R.** At a minimum, disciplines represented on the program staff should include Physical Therapy, Occupational Therapy, Speech/Language Pathology, and Rehabilitation Psychology/Neuropsychology.
- S.** The staff shall have appropriate expertise and current training in brain injury treatment.
- T.** Policy shall be in place to provide orientation to each new staff member assigned to the brain injury outpatient service on the role of each discipline.
- U.** The program director should have a minimum of two years' experience in traumatic brain injury rehabilitation management and/or specific training that will

*Adult Brain Injury Outpatient Rehabilitation Center Standards*

enable him/her to understand and respond to the unique needs of brain injured patients.

- V.** Program evaluation and quality assurance should be maintained by documenting quantifiable indices of the following:
1. Pre-treatment functional status
  2. Post-treatment functional status
  3. Pre-treatment living status
  4. Post-treatment living status
  5. Pre-treatment vocational status
  6. Post-treatment vocational status
  7. Pre-treatment academic status
  8. Post-treatment academic status
  9. Pre-treatment avocational status
  10. Post-treatment avocational status
  11. Follow-up of patient to determine to what degree the program has been successful and what program changes may be necessary to maximize success in future patients
- W.** There shall be a system for a periodic review of the program on at least an annual basis. It is encouraged that persons from outside the program participate in the process.
- X.** Advertising of the program shall be limited to program descriptions provided in such a way that the consumer or purchaser of services is aware of both the scope and limitations of the treatment program.
- Y.** There shall be a policy and procedures in place to resolve patients' concerns or grievances within an established timeframe.
- Z.** There should be a designated person responsible for ensuring new admissions are reported to the Brain and Spinal Cord Injury Central Registry.
- AA.** The rehabilitation center shall:
1. Utilize and integrate educational information developed by the Brain and Spinal Cord Injury Program, the Florida Spinal Cord Injury Resource Center and the Brain Injury Association of Florida
  2. Actively collaborate with the State of Florida, Brain and Spinal Cord Injury Program as required
- AB.** The rehabilitation center is encouraged to associate and participate with local, state and national brain injury associations.
- AC.** The rehabilitation center should address prevention of potential long-term complications resulting from brain injury, such as:

## *Adult Brain Injury Outpatient Rehabilitation Center Standards*

1. Aging with a disability
2. Co-morbidities and their potential complicating factors
3. Diet
4. Lifestyle

### **Psychology Specific Standards**

Both Rehabilitation Psychology and Clinical Neuropsychology are subspecialties within the larger profession of Psychology. The primary purpose of these specialized psychologists is to optimize adaptive function in individuals with brain injuries from a cognitive, emotional and behavioral perspective. Utilizing clinical evaluation, formal assessment, focused intervention and team consultation to promote functional outcome, these professionals are an integral part of the treatment team. They work together with the treatment team to develop and implement an individualized treatment plan. This plan of treatment and care offers cognitive, emotional, behavioral, social and physical approaches to individuals and their support systems, moving them toward recovery of independence and enhancing quality of life.

#### **AD. Staffing**

There is, at minimum, one designated doctoral level licensed psychologist with expertise in brain injury identified as the psychologist with responsibility for the brain injury service. Qualifications include a minimum of three (3) years experience working with individuals with brain injuries and ongoing professional education related to brain injury rehabilitation. Psychologists working with pediatric populations should have training, expertise and ongoing professional education in the area of pediatrics.

#### **AE. Orientation and Training**

1. Psychologists should demonstrate professional competencies in, or be provided with an orientation in at minimum, the brain injury section of the following disciplines:
  - a. Rehabilitation psychology, neuropsychology, clinical/health psychology or clinical mental health counseling
  - b. Physical therapy
  - c. Occupational therapy
  - d. Nursing
  - e. Social work/case management
  - f. Speech/language pathology
  - g. Therapeutic recreation
  - h. Vocational services
  - i. Medical specialties, e.g., physical medicine and rehabilitation, neurology, etc.
  - j. Other disciplines, e.g., dietician/nutrition, pastoral care, etc.
2. Professional competencies and/or orientation should include, but not be limited to the following:
  - a. Brain-behavior relationships
  - b. Functional sequelae of brain injury

*Adult Brain Injury Outpatient Rehabilitation Center Standards*

- c. Cognitive assessment
  - d. Emotional and behavioral assessment
  - e. Developmental assessment
  - f. Neuropsychological/cognitive screening assessment instruments
  - g. Emotional and behavior assessment instruments
  - h. Emotional adjustment and coping strategies
  - i. Assessment and management of agitation, confusional states, post-operative or medication mediated sedation effects, and depression/anxiety
  - j. Neuro-diagnostic tests (e.g., relevant imaging technologies, neurological examination related to cognitive and neuromuscular function)
  - k. Substance abuse
  - l. Sexual functioning
  - m. Family/cultural factors
  - n. Activities of daily living and principles of care-giving
  - o. Relevant medical management
  - p. Rehabilitation resources in the community
  - q. Medical records
  - r. Rehabilitation program philosophy and goals
  - s. Overview of the rehabilitation process, and the continuum of care in the context of the center
3. Psychologists must demonstrate ongoing professional education in the area of traumatic brain injury rehabilitation.
  4. Psychologists working with pediatric patients must demonstrate ongoing professional education in the area of pediatric traumatic brain injury rehabilitation.

**AF.** Clinical Procedures

1. Evaluation - Initial evaluations must be completed within the first forty-eight hours and integrated interdisciplinary treatment plans must be signed within the first four days of patient admission. Documentation should address the following, but not be limited to:
  - a. Pre-morbid cognitive, emotional and behavioral status, along with educational and vocational history
  - b. Cognitive/behavioral status of the patient
  - c. Emotional/behavioral status of the patient and family/social support system
  - d. Recommendations for optimizing rehabilitation outcome
  - e. Identification of anticipated cognitive, emotional or behavioral problems that may influence follow-up treatment or care
2. Assessment – Testing needs will be determined by the licensed psychologist. The psychologist will ensure the protection of raw test data in conjunction with medical records. Test results will be included in the patient’s medical record. The assessment may include, but not be limited to:

*Adult Brain Injury Outpatient Rehabilitation Center Standards*

---

- a. Cognitive/mental status screening
  - b. Neuropsychological testing
  - c. Intelligence testing
  - d. Emotional status testing
  - e. Consideration of vocational needs
  - f. Educational testing
  - g. Approved testing related to research projects
3. Treatment Plan – A psychology treatment plan, including current emotional, behavioral and cognitive status, goals of treatment, interventions being provided and response to treatment intervention should be developed after the initial assessment. The plan is updated as appropriate and included in the integrated team treatment plan.
4. Treatment Interventions – Treatment interventions available to brain injured patients may include, but are not limited to the following:
- a. Individual psychotherapy
  - b. Group psychotherapy
  - c. Family support
  - d. Behavioral management
  - e. Cognitive remediation
  - f. Sexual counseling
  - g. Marital counseling related to rehabilitation goals
  - h. Educational/vocational counseling
  - i. Pain management
  - j. Assertiveness/social skills training
  - k. Stress management
  - l. Play therapy
  - m. Parent training
  - n. Anger management
  - o. Neuropsychological coaching/cognitive rehabilitation
  - p. Rehabilitation education
5. Discharge Summary – There is a psychology discharge summary for each patient that includes:
- a. Pre-morbid psychological, behavioral and educational/work status
  - b. Initial cognitive, emotional and behavioral status
  - c. Treatment intervention provided
  - d. Response to treatment
  - e. Current cognitive, emotional and behavioral status
  - f. Functional capabilities
  - g. Estimated functional potential and discharge disposition
  - h. Recommendations for post outpatient rehabilitation care

*Adult Brain Injury Outpatient Rehabilitation Center Standards*

---

6. Documentation - The following psychology-related documentation must be maintained within its own section in patient charts:
    - a. Initial clinical intake evaluation, addressing cognitive, emotional and behavioral issues
    - b. Results of any formal testing performed
    - c. Psychology treatment plan and updates
    - d. Psychology service progress notes
    - e. Discharge summary
- AG.** Interdisciplinary Collaboration - Psychology services must be provided as part of an integrated interdisciplinary team approach. Psychologists and/or mental health clinicians should be involved, when appropriate, with the following:
1. Team conferences
  2. Participate in patient and family/social support conferences
  3. Consult with each discipline involved with the patient and family/social support system
  4. Liaison with local mental health resources
  5. Family education and support groups
  6. Provision of continuing professional education (in-house or external to the center) concerning psychological aspects of rehabilitating individuals with brain injuries
  7. Acute care/trauma services
- AH.** The psychologist is aware of the importance of traumatic brain injury prevention initiatives and assists the interdisciplinary rehabilitation team in these endeavors as appropriate/indicated.
- AI.** The psychologist should be involved in brain injury service-related policy and procedure development.
- AJ.** The psychologist should participate in program evaluation and quality assurance activities as appropriate/indicated.

## *Pediatric Inpatient Rehabilitation Center Standards*

---

**Rehabilitation for children differs** greatly from rehabilitation for adults because children are continuously growing and developing. In addition to knowledge and skills related to pediatric rehabilitation, professionals must have an in-depth knowledge of normal growth and development of children. They must have assessment skills related to the physical, cognitive and psychosocial development of children. They must have knowledge of interventions that can promote developmental milestones, and they must have skills needed to communicate with children and their families. Further, pediatric programs need to provide specially designated areas with age and developmentally appropriate equipment, furniture and materials for children and adolescents. In pediatric rehabilitation, it is essential to teach the family how to care and promote independence for the child while balancing their own needs and those of other family members. Thus, in pediatric rehabilitation, care is family focused and includes care and support of siblings. Self-care becomes a developmental process for both the child and their family. Emotional support and resources are necessary for the family so they can provide the positive environment needed for the child to grow, adjust and develop appropriately. To be successful, pediatric rehabilitation requires ongoing interaction between local schools and other providers in the community. The goal of pediatric rehabilitation is to promote physical, cognitive, and psychosocial growth and development so the child can achieve maximum potential. The following standards have been developed with this goal in mind.

- A.** The pediatric rehabilitation center/program shall be accredited by CARF and the Joint Commission. The pediatric age group may include those children from birth to 21 years of age. Patient groupings within the program shall respect each person's developmental and social level. Patients age 16-21 years may be designated for either a pediatric or an adult rehabilitation program. The focus of the program will reflect a family-centered approach to care and treatment, incorporating not only the pediatric patient, but all appropriate family members in the rehabilitation process – by observational and hands- on methods of involvement. Additionally, family members can be expected to be in residence during the rehabilitation program on an as-needed basis, in order to facilitate care-giving and supervision upon the patient's return to the community.
- B.** There should be a volume of admissions sufficient to support the specialized professional expertise necessary to operate a comprehensive designated pediatric rehabilitation program. It is expected that a minimum of 30 pediatric admissions per year, and an average daily census of 4-5 patients will be maintained in order to create a rehabilitation environment adequate for pediatric designation.
- C.** Each designated pediatric rehabilitation program shall make available to acute care hospitals in their catchment area, a specialized team representative to evaluate children regarding recommendations for acute rehabilitation care. It shall also provide ongoing clinical consultation upon request to those acute care hospitals.
- D.** The organization has written policies establishing criteria for admission and requiring specific patient information from referring sources (e.g., comprehensive

*Pediatric Inpatient Rehabilitation Center Standards*

medical history, associated illnesses and injuries, behavioral status, cognitive status, pre-morbid school performance, family and other support systems, pre-morbid psychosocial history, etc.). Referral sources will be educated on admission criteria. Family history and psychosocial history information should be obtained directly from the patient and family. Admission criteria and program involvement expectations and treatment program alternatives should be discussed with the family, by way of informed consent, prior to admission.

- E.** A written statement shall be kept defining the program. It should be distributed to the parents/guardians of each pediatric patient admitted to the facility. The statement shall include at minimum the following:
1. A summary of the overall program and its components
  2. Admission criteria
  3. Discharge criteria
  4. Assessment procedures
  5. Staffing patterns
  6. Quality assurance procedures
  7. Program evaluation and performance improvement procedures
  8. Post-discharge follow-up and referral procedures; linkages to community resources
- F.** The program should establish policies and procedures that identify and ensure conformity with the functions and responsibilities of the prescribing or referring physician, including:
1. Medical emergencies
  2. Exchange of pertinent medical information
  3. Brain and spinal cord injury specific complications
  4. Medical contraindication
  5. Medication review
  6. Referral to other disciplines or specialists
  7. Collaborative contact with the patient's primary care physician
- G.** Appropriate policies and procedures for referring children to community, state and other agencies should be established.
- H.** Policies and procedures for follow-up post discharge should be established. This information should be incorporated into the program evaluation system to track the frequency of successful follow-up placements, and to identify preferred follow-up services.
- I.** There should be specific and appropriate units designated for the rehabilitation of children with neuro-trauma (brain and/or spinal) that are physically separate from adult units. A pediatric unit should include the following:
1. Beds appropriate to age, developmental needs, size and medical needs of children

*Pediatric Inpatient Rehabilitation Center Standards*

2. Seats, wheelchairs and positioning systems appropriate to the age, developmental needs, size and medical needs of children
  3. Therapy equipment appropriate to the age, developmental needs, size and medical needs of children
  4. Pediatric medical equipment
  5. Availability of private rooms for individuals demonstrating medical or behavioral needs
  6. A physical environment incorporating safeguards, supervision and security to meet the unique needs of minors; including instruction and training in safety/security for pediatric patients and caregivers
- J.** There should be designated pediatric rehabilitation staff with pediatric experience whose responsibilities include:
1. Facilitating referrals and admissions to the Rehabilitation Center, as well as transfers to and from acute facilities
  2. Disseminating information to related agencies and institutions
  3. Liaison with state agencies, school systems and insurance companies
  4. Coordination of discharge planning with appropriate parties
  5. Coordination of disaster relief efforts with county and state Emergency Management officials
- K.** Nursing staffing patterns should be sufficient to provide close supervision of the pediatric patients across all shifts, and should meet and comply with CARF/Joint Commission staff-to-patient ratio.
- L.** There should be a designated person responsible for ensuring new admissions are reported to the Brain and Spinal Cord Injury Central Registry.
- M.** There should be an established process of ongoing contact with third party payers and relevant public and community agencies including, but not limited to:
1. Social Security Administration
  2. Vocational Rehabilitation
  3. Children's Medical Services
  4. Children's Mental Health Program
  5. Development Disabilities Program
  6. Local school system
  7. Department of Children and Families
  8. Alcohol, Drug Abuse and Mental Health

*Pediatric Inpatient Rehabilitation Center Standards*

9. Disability Rights Florida
  10. Legal Aid Society
  11. Juvenile Justice – Youth and Family Services
- N.** All staff providing program-related services to pediatric patients and families must have formal training and experience working with children who have survived brain and/or spinal cord injuries.
- O.** The Medical Director of the Pediatric Program must have experience in Pediatric Rehabilitation by demonstrating at least one of the following:
1. One year post graduate Pediatric Rehabilitation Fellowship
  2. Two years experience with greater than 50 percent of patient time in pediatric rehabilitation
  3. Documented long-term follow-up of 30 pediatric rehabilitation patients per year
  4. A combined adult and pediatric residency training
- P.** Medical consultation services must be available. These should include, but are not limited to, the following specialty areas in pediatrics:
1. Cardiology
  2. Gastroenterology
  3. Infectious disease
  4. Neurology
  5. Neurosurgery
  6. Ophthalmology
  7. Orthopedic surgery
  8. Otorhinolaryngology
  9. Plastic/Reconstructive surgery
  10. Psychiatry
  11. Pulmonology
  12. Surgery
  13. Urology
- Q.** All pediatric centers shall provide for the appropriate educational needs of their hospitalized patients through liaisons with local school districts, and/or educational resources.
- R.** Depending upon the needs of those served and stated goals, the pediatric center should have or make formal arrangements for the provision of the following specialty services:
1. Audiology
  2. Dentistry
  3. Dietetic/nutrition

*Pediatric Inpatient Rehabilitation Center Standards*

4. Drivers education (when necessary)
  5. Orthotics/prosthetics
  6. Pharmacy
  7. Rehabilitation engineering
  8. Respiratory therapy
  9. Sex education (when necessary)
  10. Therapeutic recreation or child life specialist
  11. Vocational services
- S.** Diagnostic services should be available or readily accessible to the attending and any consulting physician specialist, and should include:
1. All relevant electro-diagnostic services
  2. Laboratory services
  3. Relevant radiological imaging services
  4. Urodynamics
- T.** An initial formal interdisciplinary plan of care should be performed with each child and family within four days of admission, and weekly performance evaluations tied to treatment plan goals should occur throughout admission. A formal evaluation should be repeated at or near discharge. Formal evaluations must address, but are not limited to the following:
1. Medical status
  2. Social status
  3. Neurological status
  4. Health and nutrition
  5. Sensorimotor capacity, including gross and fine motor strength and control, sensation, balance, joint range of motion, mobility and function.
  6. Cognitive status
  7. Perceptual skills
  8. Communicative skills
  9. Psychological status (affect and mood)
  10. Interpersonal and social skills
  11. Behavioral status
  12. Activities of daily living, including self-care, home and community skills
  13. Recreation and leisure time skills
  14. Educational and/or prevocational capacity
  15. Employment potential (when applicable)
  16. Sexuality (when applicable)
  17. Family/Caregiver status (financial, emotional, physical, employment)
  18. Decisional capacity status (ability to render consent or assent)
  19. Residence accessibility and community reintegration (including post-discharge resources)
  20. Environmental modification, including adaptive equipment

*Pediatric Inpatient Rehabilitation Center Standards*

- U.** The interdisciplinary treatment team should meet at regular intervals to determine, implement and modify an integrated treatment plan. The patient and family members (as appropriate) should be routinely involved in this decision making process. The integrated treatment plan should include, but not be limited to, the following evaluation and treatment interventions where clinically appropriate:
1. Behavioral management program
  2. Clinical social work
  3. Cognitive rehabilitation
  4. Community reintegration skills training
  5. Educational interventions
  6. Family counseling/therapy
  7. Functional daily living skills training
  8. Medical management
  9. Occupational therapy
  10. Physical therapy
  11. Rehabilitation nursing
  12. Rehabilitation psychology, neuropsychology services
  13. Sexual functioning education (age appropriate, with parental consent as needed)
  14. Social skills training
  15. Speech and language therapy
  16. Therapeutic recreation or child life specialist
- V.** There shall be a system of documenting patient progress per contact and it must be maintained per state and federal rules/regulations.
- W.** Discharge criteria shall be based on successful achievement of the treatment program, a failure to meet minimum goals within a specific period of time, or other reasonable criteria.
- X.** Final assessments will be utilized for determining outcome and to make recommendations for further treatment/management and must be completed within one month of discharge from the program.
- Y.** Family-centered care and treatment requires that family members/guardians and siblings (as appropriate) of pediatric patients be directly involved in the evaluation, treatment and discharge planning throughout the course of admission. Family members should be afforded support services specifically tailored to meeting their needs as they prepare to fulfill caregiver/supervisory roles post-discharge. Interaction among families of pediatric patients should be fostered through programming and reinforced by the center's physical environment. In addition, the patient, family members/guardian and significant others should be provided information regarding available options for follow-up care, community services and/or alternative continuity of care programs.

*Pediatric Inpatient Rehabilitation Center Standards*

- Z.** The pediatric center shall have the capability of safely transporting patients in wheelchairs. The emphasis of transportation utilization should be for community re-entry, recreational, vocational, social activities and/or clinical follow-up appointments.
- AA.** The pediatric center's physical layout and infrastructure resources should actively support the rehabilitation of developmentally similar patients by providing appropriate developmental play activities, and by facilitating both structured and casual structured and casual family-to-family social interactions.
- AB.** Program evaluation and quality assurance should be maintained by documenting the following:
1. Pre-treatment disability rating
  2. Post-treatment disability rating
  3. Pre-treatment living status
  4. Post-treatment living status
  5. Pre-treatment vocational status (as applicable)
  6. Post-treatment vocational status (as applicable)
  7. Pre-treatment academic status
  8. Post-treatment academic status
  9. Pre-treatment avocational status
  10. Post-treatment avocational status
  11. Follow-up of children to determine what degree the program has been successful and what program changes may be necessary to maximize success in future patients
- AC.** Data should be collected on an on-going basis to permit annual evaluation of program operational effectiveness and efficiency, along with treatment outcomes specific to the pediatric program. This measurement system should include the following components:
1. Program – financial status, physical plant status, staffing status, and plans for improvement and growth
  2. Clinical Service – initial performance/status evaluations, progress measures during admission, discharge performance evaluations and post-discharge outcome evaluations
- AD.** The pediatric center shall actively collaborate with the State of Florida, Brain and Spinal Cord Injury Program as required.
- AE.** The pediatric center provides opportunities for interdisciplinary staff to participate in programs to educate the public in brain and spinal cord injury prevention and may include the following components:
1. Ongoing community/public awareness programs that may include the local media to target specific prevention concerns

*Pediatric Inpatient Rehabilitation Center Standards*

---

2. Regularly scheduled traumatic brain and/or spinal cord injury interventions with specific curriculum implemented in local elementary, middle or high schools:
    - a. Epidemiology of injury on both the local and national level
    - b. Consequences of injury (to include physical, cognitive, emotional, social and financial)
    - c. Prevention techniques
    - d. First responder considerations
    - e. Traumatic brain and/or spinal cord injured survivor(s) to relate their personal experience with injury
    - f. Concussion and sports injuries
  3. Demonstrated involvement or collaboration with other organizations involved in prevention activities
  4. Active support of legislation that will influence public policy decisions to prevent traumatic brain and spinal cord injuries
  5. Familiarity with ongoing injury prevention programs and relevant local data regarding epidemiology of injury
  6. The ability to serve as an injury prevention resource for the community
- AF.** All staff should provide documentation of continuing education credits toward securing/maintaining licensure appropriate to pediatric rehabilitation patients served per Florida licensing requirements.
- AG.** Facilities should encourage and facilitate staff participation in community and professional organizations relating to brain and/or spinal cord injury

*Pediatric Outpatient Rehabilitation Center Standards*

**A Pediatric Outpatient Rehabilitation Program** is family-centered, goal-oriented, and interdisciplinary in emphasis, specifically designed to provide a continuum of care and treatment after discharge from inpatient hospital settings. Performance goals are focused upon improving physical, cognitive, communicative, emotional, behavioral and social functioning in children survivors of traumatic brain injury and spinal cord injury within the context of their family and community environments. The program may be free-standing or a component of another rehabilitation center. The pediatric age group may include those children from birth to 21 years of age. Patient groupings within the program shall respect each person's developmental and social level. Patients age 16-21 years may be designated for either a pediatric or adult outpatient rehabilitation program.

- A.** The pediatric rehabilitation center/program shall be accredited by CARF and the Joint Commission. The pediatric age group may include those children from birth to 21 years of age. Patient groupings within the program shall respect each person's developmental and social level. Patients age 16-21 years may be designated for either a pediatric or an adult rehabilitation program. The focus of the program will reflect a family-centered approach to care and treatment, incorporating not only the pediatric patient, but all appropriate family members in the rehabilitation process – by observational and hands – on methods of involvement.
- B.** There should be a volume of admissions sufficient to support the specialized professional expertise necessary to operate a comprehensive designated pediatric rehabilitation program. It is expected that a minimum of 30 pediatric admissions per year, and an average daily census of 4-5 patients will be maintained in order to create a rehabilitation environment adequate for pediatric designation.
- C.** The organization has written policies establishing criteria for admission and requiring specific patient information from referring sources (e.g., comprehensive medical history, associated illnesses and injuries, behavioral status, cognitive status, pre-morbid school performance, family and other support systems, pre-morbid psychosocial history, etc.). Referral sources will be educated on admission criteria. Family history and psychosocial history information should be obtained directly from the patient and family. Admission criteria and program involvement expectations and treatment program alternatives should be discussed with the family, by way of informed consent, prior to admission.
- D.** The Pediatric Outpatient Rehabilitation Program should provide or make formal arrangement for the provision of the following services by professionals having training and experience with children:
  - 1. Behavioral management
  - 2. Cognitive rehabilitation
  - 3. Community resources
  - 4. Education services appropriate to the child's level

*Pediatric Outpatient Rehabilitation Center Standards*

5. Neuropsychological and emotional/behavior services
  6. Occupational therapy services
  7. Physical restoration services including physical therapy
  8. Pre-vocational or vocational services as appropriate
  9. Recreation and leisure activities
  10. Speech/language pathology services
- E.** A written statement shall be kept defining the program and should be distributed to the parents/guardians of each pediatric patient admitted to the facility. The statement shall include at minimum the following:
1. A summary of the overall program and its components
  2. Admission criteria
  3. Discharge criteria
  4. Assessment procedures
  5. Staffing patterns
  6. Quality assurance procedures
  7. Program evaluation and performance improvement procedures
  8. Post-discharge follow-up and referral procedures; linkages to community resources
- F.** There shall be a formalized initial plan of care to identify the needs and strengths of each child and family admitted to the program within two weeks of admission. The findings will assist in establishing objective and measurable performance goals to be accomplished during the course of treatment. Progress will be tracked and documented at least once per month throughout the course of treatment.
- G.** An individualized written treatment plan will determine the specific treatments and services provided for each child and family admitted to the program. This plan will specify realistic, objective and measurable treatment goals and objectives, as well as estimated time frames for goal achievement, discharge goals and transitions among program treatment components. The individualized treatment plan should:
1. Focus on optimizing independent function within the context of the child's home environment and the family system nested in the community.
  2. Relate to community referral information regarding the child's specific need
  3. Preserve the dignity and personal safety of the child
  4. Be reviewed at regular intervals by the treatment team, patient (as appropriate) and family to evaluate progress, methods and goals
  5. Ensure coordination with community-based treatments provided outside the program
  6. Be addressed with respect to goal achievement in each discipline's discharge summary
  7. Address services designed to support family needs
  8. Provide for community reintegration services, especially regarding the child's return to school, which shall be overseen by the program director or assignees on a regular basis

*Pediatric Outpatient Rehabilitation Center Standards*  
.....

- H.** The program should establish policies and procedures that identify and ensure conformity with the functions and responsibilities of the prescribing or referring physician, including:
1. Medical emergencies
  2. Exchange of pertinent medical information
  3. Brain and spinal cord injury specific complications
  4. Medical contraindication
  5. Medication review
  6. Referral to other disciplines or specialists
  7. Collaborative contact with the patient's primary care physician
- I.** Medical consultation services should include, but not be limited to, the following specialty areas in pediatrics:
1. Cardiology
  2. Gastroenterology
  3. Infectious disease
  4. Neurology
  5. Neurosurgery
  6. Ophthalmology
  7. Orthopedic surgery
  8. Otorhinolaryngology
  9. Physical Medicine and Rehabilitation
  10. Plastic/reconstructive surgery
  11. Psychiatry
  12. Pulmonology
  13. Surgery
  14. Urology
- J.** Depending upon the needs of those served and stated goals, the program should have or make formal arrangements for the provision of the following services:
1. Audiology
  2. Dentistry
  3. Dietetic/nutrition
  4. Drivers education (when necessary)
  5. Nursing
  6. Orthotics/prosthetics
  7. Pharmacy
  8. Rehabilitation engineering
  9. Respiratory therapy
  10. Sexuality (age appropriate, when applicable)
  11. Therapeutic recreation or child life specialist
  12. Vocational services
- K.** There should be an established process of ongoing contact with third party payers and relevant public and community agencies including, but not limited to:

*Pediatric Outpatient Rehabilitation Center Standards*

1. Social Security Administration
  2. Vocational Rehabilitation
  3. Children's Medical Services
  4. Children's Mental Health Program
  5. Development Disabilities Program
  6. Local school system
  7. Department of Children and Families
  8. Alcohol, Drug Abuse and Mental Health
  9. Disability Rights Florida
  10. Legal Aid Society
  11. Juvenile Justice – Youth and Family Services
- L.** Diagnostic services should be available or readily accessible to the attending and any consulting physician specialist, and should include:
1. All relevant electro-diagnostic services
  2. Laboratory services
  3. Relevant radiological imaging services
  4. Urodynamics
- M.** Appropriate policies and procedures for referring children to community, state and other agencies should be established.
- N.** Policies and procedures for follow-up post discharge should be established. This information should be incorporated into the program evaluation system to track the frequency of successful follow-up placements, and to identify preferred follow-up services.
- O.** Individual case conferences shall occur at least once per month. All treatment team members should be present or represented for the purpose of reviewing progress and updating the interdisciplinary treatment plan. The patient and family (as appropriate) should be involved in this periodic progress review. Additionally, support services provided to the family (related to specified family goals) should be incorporated into the treatment plan and progress routinely tracked. Decisions to substantially change the treatment plan require the agreement of the patient and family (as appropriate). Formal conference summaries should be included in the case record containing objective data, progress noted, intended treatment and expected discharge status.
- P.** There shall be a system of documenting patient progress per contact and it must be maintained per state and federal rules/regulations.
- Q.** Discharge criteria shall be based on successful achievement of the treatment program, a failure to meet minimum goals within a specific period of time, or other reasonable criteria.

*Pediatric Outpatient Rehabilitation Center Standards*  
.....

- R.** Final assessments will be utilized for determining outcome and to make recommendations for further treatment/management and must be completed within one month of discharge from the program.
- S.** There should be designated pediatric rehabilitation staff with pediatric experience whose responsibilities include:
1. Facilitating referrals and admissions to the Rehabilitation Center, as well as transfers to and from acute facilities
  2. Disseminating information to related agencies and institutions
  3. Liaison with state agencies, school systems and insurance companies
  4. Coordination of discharge planning with appropriate parties
  5. Coordination of disaster relief efforts with county and state Emergency Management officials
- T.** The program director should have a minimum of two years experience in brain and/or spinal cord injury rehabilitation management and/or pediatric specific training that will enable him/her to understand and respond to the unique needs of pediatric patients with traumatic brain and/or spinal cord injuries.
- U.** The medical director of the pediatric program must have experience in pediatric rehabilitation by demonstrating at least one of the following:
1. One year post graduate Pediatric Rehabilitation Fellowship
  2. Two years experience with greater than 50 percent of patient time in pediatric rehabilitation
  3. Documented long-term follow-up of 30 pediatric rehabilitation patients per year
  4. A combined adult and pediatric residency training
- V.** All staff providing program-related services to pediatric patients and families must have formal training and experience working with children who have survived brain and/or spinal cord injuries.
- W.** All staff should provide documentation of continuing education credits toward securing/maintaining licensure appropriate to pediatric rehabilitation patients served per Florida licensing requirements.
- X.** Facilities should encourage and facilitate staff participation in community and professional organizations relating to traumatic brain and/or spinal cord injury.

*Pediatric Outpatient Rehabilitation Center Standards*  
.....

- Y.** Professional personnel should maintain one-to-one treatment contact with each child at a frequency sufficient for professional oversight and input to the treatment process.
- Z.** Program evaluation and quality assurance should be maintained by documenting the following:
1. Pre-treatment disability rating
  2. Post-treatment disability rating
  3. Pre-treatment living status
  4. Post-treatment living status
  5. Pre-treatment vocational status (as applicable)
  6. Post-treatment vocational status (as applicable)
  7. Pre-treatment academic status
  8. Post-treatment academic status
  9. Pre-treatment avocational status
  10. Post-treatment avocational status
  11. Follow-up of children to determine what degree the program has been successful and what program changes may be necessary to maximize success in future patients
- AA.** Data should be collected on an on-going basis to permit annual evaluation of program operational effectiveness and efficiency, along with treatment outcomes specific to the pediatric program. This measurement system should include the following components:
1. Program – financial status, physical plant status, staffing status, and plans for improvement and growth
  2. Clinical Service – initial performance/status evaluations, progress measures during admission, discharge performance evaluations and post-discharge outcome evaluations
- AB.** There should be a designated person responsible for ensuring new admissions are reported to the Brain and Spinal Cord Injury Central Registry.

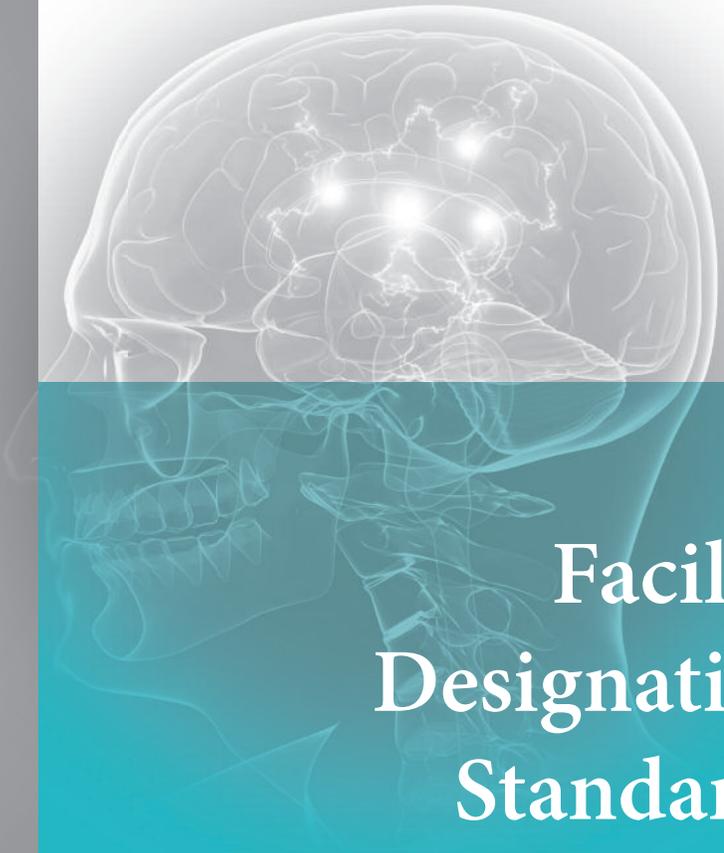
*Pediatric Outpatient Rehabilitation Center Standards*

---

- AC.** The pediatric center shall actively collaborate with the State of Florida, Brain and Spinal Cord Injury Program as required.
- AD.** The pediatric center provides opportunities for interdisciplinary staff to participate in programs to educate the public in traumatic brain and spinal cord injury prevention and may include the following components:
1. Ongoing community/public awareness programs that may include the local media to target specific prevention concerns
  2. Regularly scheduled traumatic brain and/or spinal cord injury interventions with specific curriculum implemented in local elementary, middle or high schools:
    - a. Epidemiology of injury on both the local and national level
    - b. Consequences of injury (to include physical, cognitive, emotional, social and financial)
    - c. Prevention techniques
    - d. First responder considerations
    - e. Traumatic brain and spinal cord injured survivor(s) to relate their personal experience with injury
    - f. Concussion and sports injuries
  3. Demonstrated involvement or collaboration with other organizations involved in prevention activities
  4. Active support of legislation that will influence public policy decisions to prevent traumatic brain and spinal cord injuries
  5. Familiarity with ongoing injury prevention programs and relevant local data regarding epidemiology of injury
  6. The ability to serve as an injury prevention resource for the community

The Florida  
Department of Health

# Brain & Spinal Cord Injury Program



## Facility Designation Standards

Revised July 2013

The Brain and Spinal Cord Injury Program  
Florida Department of Health  
4052 Bald Cypress Way, BIN C-25  
Tallahassee, FL 32399 - 1744  
(850) 245-4045  
[www.FLHealth.gov](http://www.FLHealth.gov)  
search phrase: brain and spinal cord injury program