

THE FLORIDA
DEPARTMENT OF HEALTH



**Brain &
Spinal
Cord
Injury
Program**



**Facility
Designation
Standards**

Revised April 2005



Prior to World War II,

a person sustaining a complete spinal cord injury had almost no chance of survival. Since this time, there have been major improvements stemming from the development of specialized spinal cord injury units initiated in England in the 1940–50s.

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Foreword

Section 381.74, Florida Statutes, mandates the establishment of a Brain and Spinal Cord Injury Central Registry in the Florida Department of Health, Bureau of Brain and Spinal Cord Injury Program (BSCIP). Every public, private, health and social agency is required to report injuries to the Central Registry. The Registry is located in the state office, and can be reached at 1-800-342-0778. Hospitals, attending physicians, public and private agencies are required to report injuries within five days. Data collected enables the BSCIP to develop brain and spinal cord injury treatment and rehabilitation programs. Furthermore, it is to ensure that the referred person with the brain or spinal cord injury is given the opportunity to obtain appropriate rehabilitation services rendered by the program and other providers.

Section 381.75, Florida Statutes, requires that the program develop a multilevel plan of care for persons with brain and spinal cord injuries in Florida. This plan provides standards for emergency medical services, acute care hospitalization, inpatient and outpatient medical rehabilitation services and transitional living services.

Section 381.78, Florida Statutes, requires that the Secretary of the Department of Health appoint individuals as members of the Brain and Spinal Cord Injury Advisory Council. They, along with many other individuals who served on various committees, are to be commended for their diligence, dedication and accomplishments in developing the standards and criteria for this coordinated system of care for persons with brain and spinal cord injuries.

Support for the Brain and Spinal Cord Injury Plan

Representatives of many public and private rehabilitation institutions, programs and agencies participated in the development of this plan. We wish to thank the following for their past and ongoing contributions and support.

Baptist Hospital, Miami, FL

Baptist Hospital, Pensacola, FL

West Florida Medical Center, Pensacola, FL
(formerly, West Florida Hospital)

West Florida Rehabilitation Institute, Pensacola, FL
(formerly, West Florida Hospital)

Homestead Transitional Living Facility, Pensacola, FL

Tallahassee Memorial Healthcare, Tallahassee, FL

(formerly, Tallahassee Regional Memorial Medical Center)

Shands Hospital, Gainesville, FL

Shands Rehab Hospital, Gainesville, FL

Shands Hospital, Jacksonville, FL
(formerly University Medical Center)

Brooks Rehabilitation Hospital, Jacksonville, FL
(formerly, Genesis Rehabilitation Hospital)

Transitions at Abilities, Clearwater, FL

Tampa General Hospital, Tampa, FL

Tampa General Rehabilitation Center, Tampa, FL

Winter Haven Hospital, Winter Haven, FL

Lucerne Medical Center, Orlando, FL
(formerly, Humana Hospital-Lucerne)

Lucerne Medical Center, Orlando, FL
(formerly Lucerne Spinal Injury Center)

Accessible Alternatives, Inc., Orlando, FL

Normandy Manor, Orlando, FL

Pinecrest Rehabilitation Hospital, Delray Beach, FL

Jackson Memorial Hospital, Miami, FL

Jackson Memorial Rehabilitation Hospital, Miami, FL

Halifax Medical Center, Daytona Beach, FL
(formerly, Halifax Hospital)

Bayfront Medical Center, St. Petersburg, FL

Rehab Solutions, Tampa, FL
(formerly, Cognitive Rehabilitation Institute)

Orlando Regional Medical Center, Orlando, FL

Florida Hospital Medical Center, Orlando, FL
 Florida Hospital Rehabilitation Center, Orlando, FL
 Sand Lake Hospital/BIRC, Orlando, FL
 HealthSouth Rehabilitation Hospital, Sarasota, FL
(formerly, Rehabilitation Institute of Sarasota)
 HealthSouth Sunrise Rehabilitation Hospital, Sunrise, FL
(formerly, Sunrise Rehabilitation Hospital)
 HealthSouth Rehabilitation Hospital, Miami, FL
 HealthSouth Sea Pines Rehabilitation Hospital,
 Melbourne, FL
 Health Rehabilitation Hospital, Tallahassee, FL
 Health Rehabilitation Hospital, Largo, FL
 Biscayne Bay Rehabilitation Center, Miami, FL
 Florida Institute for Neurologic Rehabilitation, Wauchula, FL
 Florida Medical Society
 Florida Pediatricians Society
 Florida Hospital Association
 Brain Injury Association of Florida, Inc., Pompano, FL
(formerly, Florida Head Injury Association)
 Florida Spinal Cord Injury Resource Center, Tampa, FL
 Florida Association for Rehabilitation Facilities
 Florida Rehabilitation Association
 Florida Department of Children and Families
*(formerly, Department of Health and Rehabilitative
 Services)*
 Centers for Disease Control and Prevention
 Developmental Disabilities Council
 Moreo Construction
 Mid-Florida Rehabilitation, Winter Haven, FL
 Esteem Program, Winter Haven, FL
 CSS/Optimal Environments, Inc., Tampa, FL
(formerly Optimal Environments, Inc.)
 St. Mary's Medical Center, West Palm Beach, FL
 Memorial Regional Hospital, Hollywood, FL
 Florida Department of Education

Acknowledgements

The Brain and Spinal Cord Injury Program gratefully acknowledges the expert contributions and dedication of past and present members of the Brain and Spinal Cord Injury Advisory Council, committees and various subcommittees who gave advice, consultation, and expertise in developing the Brain and Spinal Cord Injury Program Designation Facility Standards.

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Former Council Members

The following former Brain and Spinal Cord Injury Advisory Council members made valuable contributions to the development of the Brain and Spinal Cord Injury Program. We recognize them for their wisdom, insight and contribution to the program and thank them on behalf of the thousands of residents who have benefited from the program:

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 Naomi Able, M.D.
 Doug Dennis, MA
 David Cahill, Cahill, M.D.

Council Members Emeritus

The following individuals are recognized as council members emeritus for their outstanding, long-term commitment and contributions to the council, the Brain and Spinal Cord Injury Program and service to persons with brain and spinal cord injuries:

Barth Green, M.D.
 Donald Mellman, M.D.
 Joe Veisz
 Bernard S. Brucker, Ph.D.
 J. Darrell Shea, M.D.

James W. Bruce, Ph.D.
Lifetime Achievement Award

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Introduction

The development of the Brain and Spinal Cord Injury Program

In 1973, a group of concerned Florida professionals convened in Miami to organize a committee for promoting better care to individuals who sustained traumatic spinal cord injuries. Prior to this, the management of patients with spinal cord injuries was fragmented with multiple medical specialties providing specific services in the absence of an overall plan of care. This led, in many instances, to unsatisfactory results for the individuals, their families, and the state. The activities of this committee prompted the 1974 Florida Legislature to establish into law the nation's first Central Registry, which requires all hospitals and other health care providers to report all individuals who sustain spinal cord injuries. In 1976, the Legislature subsequently passed the Omnibus Nursing Home Reform Act. This legislation mandated the program to develop a coordinated system of care to address the medical and rehabilitation needs of individuals with spinal cord injuries. It also required the program to conduct an annual evaluation of nursing homes to ensure that all individuals with SCI under the age of 55 were given the opportunity to benefit by rehabilitation services.

In 1987, the Central Registry began to collect data on traumatic brain injuries. The state proactively began to address the seriousness and magnitude of services needed for this population. Additional staff was hired to assist the Spinal Cord Injury Program in the development of a new program.

In 1988, the Florida Legislature created the Impaired Drivers Speeders Trust Fund, which was renamed the Brain and Spinal Cord Injury Rehabilitation Trust Fund in 1994. Revenue for this fund is obtained from a percentage of all civil penalties, DUI and BUI convictions and temporary tags. These funds are appropriated to the program for the provision of rehabilitation services to eligible residents of the state.

Spinal Cord Injury

Magnitude of the Problem

Background: Spinal cord injury has been described by clinicians as one of the most catastrophic conditions in all of medicine. The spinal cord is a unique nerve center and transmitter of nerve impulses which controls sensation, movement, posture, bowel, bladder, respiration, circulation and sexual function. Damage to the spinal cord frequently results in a disability of significant magnitude.

The prognosis of individuals with spinal cord injury was poor well into the twentieth century. Prior to World War II, a person sustaining a complete spinal cord injury had almost no chance of survival.

Since that time, there have been major improvements stemming from the development of specialized spinal cord injury units initiated in England in the 1940–50s.

Through the efforts of a few government scientists and individual physicians practicing rehabilitation medicine, the Rehabilitation Services Administration, (an agency of the Department of Health, Education and Welfare), began to support research and demonstration projects for the development of model systems of care for the treatment of individuals with spinal cord injuries.

The Spinal Cord Injury Program in the state of Florida evolved from those initial efforts. The goal and objective of the state program was to develop a coordinated multi-level system of care that ensured all individuals who sustained traumatic spinal cord injuries receive appropriate treatment from the accident site through the process of acute care, rehabilitation, and finally their return to the community.

Incidence: Spinal cord injuries that require medical/rehabilitative services in the United States average is 40 per million, or approximately 11,000 per year. The prevalence of spinal cord injury is estimated to be approximately 245,000. Approximately 600 individuals with new spinal cord injuries are reported to the Central Registry annually in Florida. Spinal cord injuries occur primarily to males between the ages of 21-34 and 45-64. In Florida, the major causes of spinal cord injury are traffic-related crashes, followed by violence and falls. The life expectancy and long-term prognosis is rapidly improving with proper medical care and rehabilitation.

Following a spinal cord injury, the average length of acute hospitalization and rehabilitation is approximately 41 days. The average cost for acute hospitalization and

inpatient rehabilitation in the first year of injury could be as much as \$400,000. This excludes associated costs for home and vehicle modifications, durable medical equipment and supplies, or personal assistance services that may be required. The average long-term care cost ranges from a minimum of several thousand to \$122,000+ annually based on the level of injury and extent of neurological and functional impairment.

Brain Injury

Background: A brain injury is a traumatic insult to the brain. Although this injury is not always visible, it may cause physical, intellectual, emotional, social, and vocational changes. These changes affect not only the present, but future status of the individual. Consequently, most individuals who sustain this type of injury may never be quite the same again. The psychological, behavioral, and intellectual consequence of traumatic brain injury can be devastating to that person and family members.

Closed brain injury often occurs as a result of a rapid acceleration/deceleration whereby the brain is whipped back and forth in quick motion. This places extreme stress on the brain stem, which connects the large part of the brain with the spinal cord and the rest of the body. A large number of functions are packed tightly in the brain stem; i.e., control of consciousness, breathing, heartbeat, eye movements, pupil reactions, swallowing and facial movements. The stress of rapid deceleration pulls apart nerve fibers, and causes damage to the activated system of neuro-fibers that send out important messages to all parts of the body. Brain injury may occur following cardiac arrest, stroke and other incidents, such as drowning, and many other causes due to anoxia (loss of oxygen to the brain). Open brain injury is a visible assault and may be the result of a crash, gunshot wound or a variety of other outside factors.

Each person's system is unique. Therefore, depending upon the extent and location of the brain injury, one or more physical disabilities can occur, such as impaired learning or cognitive ability, psychosocial, behavioral, or emotional impairments.

By all accounts, traumatic brain injury is a problem of major proportion justifying its label "the silent epidemic." One way to grasp the enormity of traumatic brain injury is to compare it with the incidence of spinal cord injury. Traumatic brain injury occurs five times more often than spinal cord injury.

Incidence:

- Each year over 20,000 Floridians sustain a minor, moderate or severe brain injury.
- Of this number, 5,000 will die, and most of the deaths will occur at the time of the injury or in the first two hours of hospitalization.
- Of those who survive each year, 2,500 will endure (moderate/severe) lifelong debilitating loss of function and just over 100 will remain in a persistent vegetative state.

The yearly incidence of a person or persons left with disabilities following a brain injury is significantly higher than other major neurological impairments, such as Parkinsons disease, cerebral palsy, spinal cord injuries or multiple sclerosis. Other statistics about brain injury include the following:

- Young men between the ages of 21 to 34 have the highest rate of injury, and young males are more likely to sustain serious brain injury than females.
- Traumatic brain injury is the leading killer and cause of disability in children and young adults.
- Approximately one half of all traumatic brain injuries are traffic-related followed by falls and violence.
- Each year, an estimated 3,500 children in the state of Florida sustain bicycle-related brain injuries, and over 20 of these children will die.

A survivor of a severe traumatic brain injury may require lifelong comprehensive services. The estimated cost may exceed millions of dollars to cover the care needed over their lifetime.

The long-term prognosis for individuals with brain and/or spinal cord injury has improved dramatically. Today, fewer individuals are dying from their injuries. Survivors are living longer, more productive lives. With proper medical and rehabilitation treatment, vocational services and expansion of community resources, individuals with brain or spinal cord injuries can be expected to approach normal life expectancy and function independently in the community.

Statement of Need

The Brain and Spinal Cord Injury Program provides acute care, inpatient and outpatient rehabilitation care, transitional living services, adaptive modifications and devices, prevention, education, basic research, and long-term community supports. Medical and rehabilitative services are provided in state-designated facilities that meet standards established in this plan. Although Florida has a nationally prominent and unique system of care, the need still exists to develop and expand community-based programs and to promote community reintegration. This will encourage a continuum of care directed toward an outcome of independence.

The initial efforts of the Brain and Spinal Cord Injury Program focused on the early identification and provision of acute medical care and rehabilitation through a coordinated multi-level system of designated facilities. It was clearly recognized that state and local resources presently did not go far enough to address the needs of clients and families following discharge. Without adequate community based services, the program will not be able to achieve the goals and objectives of community reintegration.

Presently, there are significant gaps in the services needed to realize the goal of community reintegration (e.g., long term neurological residential programs, respiratory care, respite care, personal assistant services, day activity programs, recreational and vocational oriented programs).

Recognizing this need, the BSCIP implemented the Medicaid Home and Community-Based Waiver, effective July 1999. The waiver enables the program to provide the long-term community-based support needed to safely integrate and maintain these individuals in the community. As of 2005, the Waiver is serving approximately 300 individuals in the community who would otherwise reside in a skilled nursing facility.

Mission: To provide all eligible residents who sustain a traumatic brain or spinal cord injury the opportunity to obtain the necessary services enabling them to return to their community.

Goals: To reintegrate injured individuals into their communities, to ensure that quality services are delivered in the most effective manner through a coordinated system, and to utilize program funds to leverage federal dollars and grants to support the long-term goals of the program.

Objectives: The objectives of the Brain and Spinal Cord Injury Program Plan are to:

- Develop, coordinate, and provide essential services to enable individuals to function as independently as possible in their community.
- Develop and maintain a coordinated system of medical, rehabilitation and community-based programs and services.
- Ensure that each individual is provided the opportunity to obtain the most appropriate and up to date care and services.
- Ensure that each eligible individual is identified and provided prompt access into the coordinated system of services.
- Ensure that each individual progresses in a timely and efficient manner through each component of the system.
- Support research activities leading toward improved functioning and methods of delivering care and services.
- Review and update the state plan as needed to ensure provision of quality services.
- Support public information, prevention and education programs to reduce the incidence of brain and spinal cord injuries and secondary complications.

State definition of “brain injury”

An insult to the skull, brain or its covering, resulting from external trauma, that produces an altered state of consciousness or anatomic, motor, sensory, cognitive or behavioral deficits.

State definition of “spinal cord injury”

A lesion to the spinal cord or cauda equina resulting from external trauma with evidence of significant involvement of two of the following deficits or dysfunctions: (1) Motor deficit, (2) Sensory deficit, or (3) Bowel and bladder dysfunction.

Eligibility

Any individual who sustains a traumatic brain or spinal cord injury and who meets the following requirements is eligible for services of the Brain and Spinal Cord Injury Program. The individual must:

- Be referred to the Central Registry.
- Be a legal resident of Florida.
- Be medically stable.
- Meet the state definition for spinal cord and/or moderate to severe brain injury.
- Have a reasonable expectation to benefit from rehabilitation services based upon the goal of community reintegration.

State designation

For a facility to become a Brain and Spinal Cord Injury Program facility, it must comply with the standards and criteria established in this state plan. Designated facilities are required to maintain the highest level of expertise and experience to address the medical, rehabilitation, and psychosocial needs of individuals who sustain traumatic brain and spinal cord injuries. These regional facilities are strategically located throughout the state to ensure accessibility and volume of new admissions. A minimum number of new admissions is required to maintain the expertise of professional staff and level of comprehensive program required. The need for facilities is based on several factors including:

1. Geographical location.
2. Incidence of traumatic brain and spinal cord injuries in a region.
3. Preponderance of need in a specific region.

To become a BSCIP designated facility, the organization must apply through the formal application process. Facilities requesting designation are sent an application package including the applicable standards and criteria. The facility must submit the completed application including a list of new admissions. The application will be reviewed by the BSCIP staff or peer review committee to ensure compliance with the standards and criteria established in the BSCIP state plan. If the program determines there is a need for additional facilities based on incidences reported, geographic location, and preponderance of need, the program will proceed with the site review process. The BSCIP is responsible for coordinating and conducting the site reviews. Site reviewers are selected from an approved register. Every effort is made to select reviewers from other geographic locations. The team consists of professionals with specific knowledge and experience needed to ensure compliance with the standards. Facilities who meet the core standards are awarded a one or three year BSCIP designation.

To ensure individuals are provided the highest quality services, funding from the BSCIP is restricted to BSCIP designated facilities and approved vendors.

All designated facilities are encouraged to promote their designation as a state designated brain and spinal cord injury center. For additional information or to request an application, please call 850-245-4045.

Designation Policies and Procedures

Process for designation as a state Brain and Spinal Cord Injury Program:

1. Interested centers must contact the Brain and Spinal Cord Injury Program office.
2. The Brain and Spinal Cord Injury Program sends the application, program standards and description of the site review process.
3. The center reviews standards to determine eligibility.
4. The center mails completed application and supportive documentation to the Brain and Spinal Cord Injury Program.
5. The Brain and Spinal Cord Injury Program reviews the application.
6. The Brain and Spinal Cord Injury Program evaluates and determines need for an additional facility. This is based on geographical location, incidence and preponderance of need in a specific area.
7. The Brain and Spinal Cord Injury Program contacts the facility to coordinate the site review.
8. The site review transpires, an exit interview follows the review, and the facility is advised of major findings.
9. The Brain and Spinal Cord Injury Program makes a decision regarding designation (3-year) or conditional designation (1-year) for the facility.
10. The Brain and Spinal Cord Injury Program notifies the facility of its designation as a state designated Brain and Spinal Cord Injury Center.
11. When an inpatient rehabilitation facility is seeking to become a state designated facility and is a fully accredited CARF program with specific accreditation in spinal cord injury and/or brain injury the program may be eligible for a modified site review process. However, if a facility that is seeking to become a state designated facility and is CARF accredited without the specialty accreditation in spinal cord injury and or brain injury, a regular site review protocol will be followed. Please refer to specific standards in question concerning your type of program.
12. Standards for Acute Care do not apply for a modified review form and are subject to a full review as stipulated. Acute care facilities seeking to be a trauma center Level I or Level II may also seek special designation as a state designated Acute Care Center for the

Brain and Spinal Cord Injury Program. Hospitals that do not qualify or desire to become a Trauma Center, but still wish to be a state designated Acute Care Center may submit an application, however, it should be noted that EMS trauma protocols require all trauma classified patients to be transported to a State Approved Trauma Center Level I, Level II or State Approved Pediatric Trauma Center, and may be past over for delivery of patients.

To be designated, the facility should meet each of the standards and criteria established in the BSCIP state plan. While an organization may not be in full compliance with every applicable standard, the decision is based upon the facility's strengths with those areas needing improvement. The following guidelines are used by the Brain and Spinal Cord Injury Program in determining the designation outcome.

Three-year full designation

The facility meets each of the designation criteria and shows overall compliance with the standards. Its programs and practices are designed and implemented to benefit the people it serves. Its program, personnel and documentation clearly indicates that present conditions represent an established pattern of total operation and that these conditions are likely to be maintained and/or improved in the foreseeable future.

One-year conditional designation

The facility meets each of the designation criteria. Although there are deficiencies in relation to the standards, there is evidence of capability to correct the deficiencies, and the program is benefiting the people it serves. Verification of corrective action is made via the mail or through a return visit, as appropriate. The final decision on designation is then made on the basis of the site survey and corrective action findings. The organization must achieve a three-year full designation following two consecutive designations or be non-designated.

Non-designated

The facility has major deficiencies in several areas of the standards, and there are serious questions as to the rehabilitation benefits to the people it serves; the organization has failed over time to bring itself into substantial conformance with the standards; or the organization has failed to meet any of the designation criteria.

A facility may be considered to be functioning between

the three-year and one-year level previously described because of certain problem areas. In this instance, designation for one-year will be awarded.

A. Brain and Spinal Cord Injury Program site reviewer process:

1. How to Qualify: All persons interested in becoming site reviewers of the Brain and Spinal Cord Injury Program must do the following in order to qualify:

- a. Complete a Site Reviewer Application Form and send it to the Brain and Spinal Cord Injury Program office with a resume.
- b. Complete a training session for site reviewers sponsored by the Brain and Spinal Cord Injury Program.

Site reviewers may be facility administrators, psychologists, physicians and nurses, with demonstrated knowledge and experience in the treatment and rehabilitation of individuals with brain and spinal cord injuries and interested in improving services to individuals with traumatic brain and spinal cord injuries.

B. Site Reviewers Screening Committee:

1. The Site Reviewers Screening Committee will assist the Brain and Spinal Cord Injury Program office in reviewing applications for designation as a state Brain and Spinal Cord Injury Center. Volunteers approved by the program office will do a paper review of applications assigned to them in order to:

- a. See if the applicant meets the Brain and Spinal Cord Injury Program standards specific to the program.
- b. Note any exceptions to the standards identified by the applicants.
- c. Identify applicants who do not appear to meet the standards.

C. After completing the review, the screening committee members will return the application to the Brain and Spinal Cord Injury Program office with their comments. All materials should be held in confidence, and no copies may be made of the application by any screening committee members. The program office will determine the site review schedule based on need. Any questions should be directed to the program office at (850)245-4045 or 1(866)875-5660.

D. Selection of site reviewers:

1. Site reviewers will be selected by the Brain and Spinal Cord Injury Program office using the following criteria:

- a. Reviewers will be selected from disciplines who have knowledge and experience in the type of facility being reviewed. For example, Pediatric knowledge and experience will be required of individuals reviewing pediatric programs.
- b. Teams will be limited to the essential number of reviewers required to minimize disruption to the facility/program being reviewed.
- c. An effort will be made to select reviewers who live far enough away from the facility to be impartial.

E. Preparation for a site review:

1. Prior to a site review, reviewers will be provided with the following information:

- a. The Brain and Spinal Cord Injury Program standards for the program they will review.
- b. Site review forms.
- c. A copy of the application and other pertinent correspondence from the facility.
- d. A description of the facility to be visited (brochures or other information available) in order to orient the reviewers to the context in which they will be reviewing.
- e. Directions to and contact persons at the facility;
- f. Instructions regarding the site review process.

2. Site reviewers will be expected to review the materials mailed to them prior to the site visit. Any questions about the review process, the facility, etc., should be directed to the Brain and Spinal Cord Injury Program.

F. Site review methodology:

1. Site review teams will consist of professionals who:

- a. Have a minimum of three (3) years experience with rehabilitation of individuals with brain and spinal cord injuries.
- b. Have submitted a Site Reviewer Application Form and a resume to the Brain and Spinal Cord Injury Program office.

2. Site reviewers will be accepted by virtue of their experi-

ence with brain and spinal cord injury rehabilitations, as well as their apparent ability to objectively review facilities and to provide feedback to both the facility and BSCIP.

3. Site reviewers will be trained by the BSCIP in site review methodology and in interpretation of the BSCIP standards and criteria.

4. Site review teams will consist of the appropriate professionals required to survey each of the standards in the plan. They will be selected by BSCIP from a register of approved reviewers.

G. After the site review:

1. Facilities will receive an exit interview immediately following the site review. They will be asked to fill out a Review Process Feedback Questionnaire and mail it within ten (10) working days to the Brain and Spinal Cord Injury Program Office. Facilities will also be asked to complete Reviewer Performance Feedback Questionnaires for each site reviewer within ten (10) days of the site visit. These questionnaires will be used to assist the Brain and Spinal Cord Injury Program office in the future training and assignment of site reviewers.

2. Site reviewers will be expected to send their completed, typed survey forms to the Brain and Spinal Cord Injury Program office within ten (10) working days following the site review.

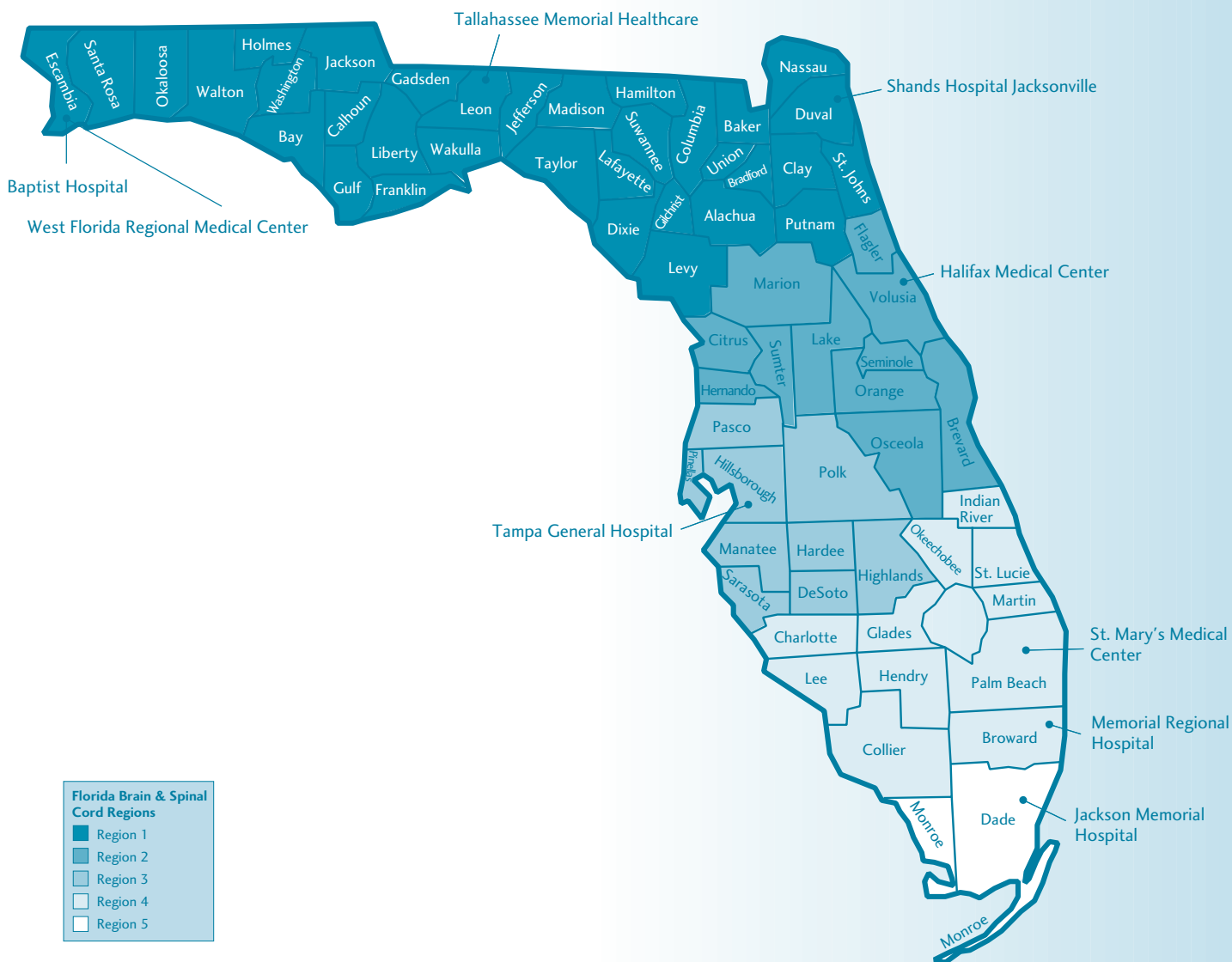
3. If reviewers encounter any problems with the facility, they should discuss these with the Brain and Spinal Cord Injury Program office directly.

4. The BSCIP will compile the reports from the individual site reviewers and send a written report to the facility within sixty (60) days following the site review. This report will be copied to the site reviewers. The information contained in the report should be treated with discretion by the site reviewers. The report will contain the following:

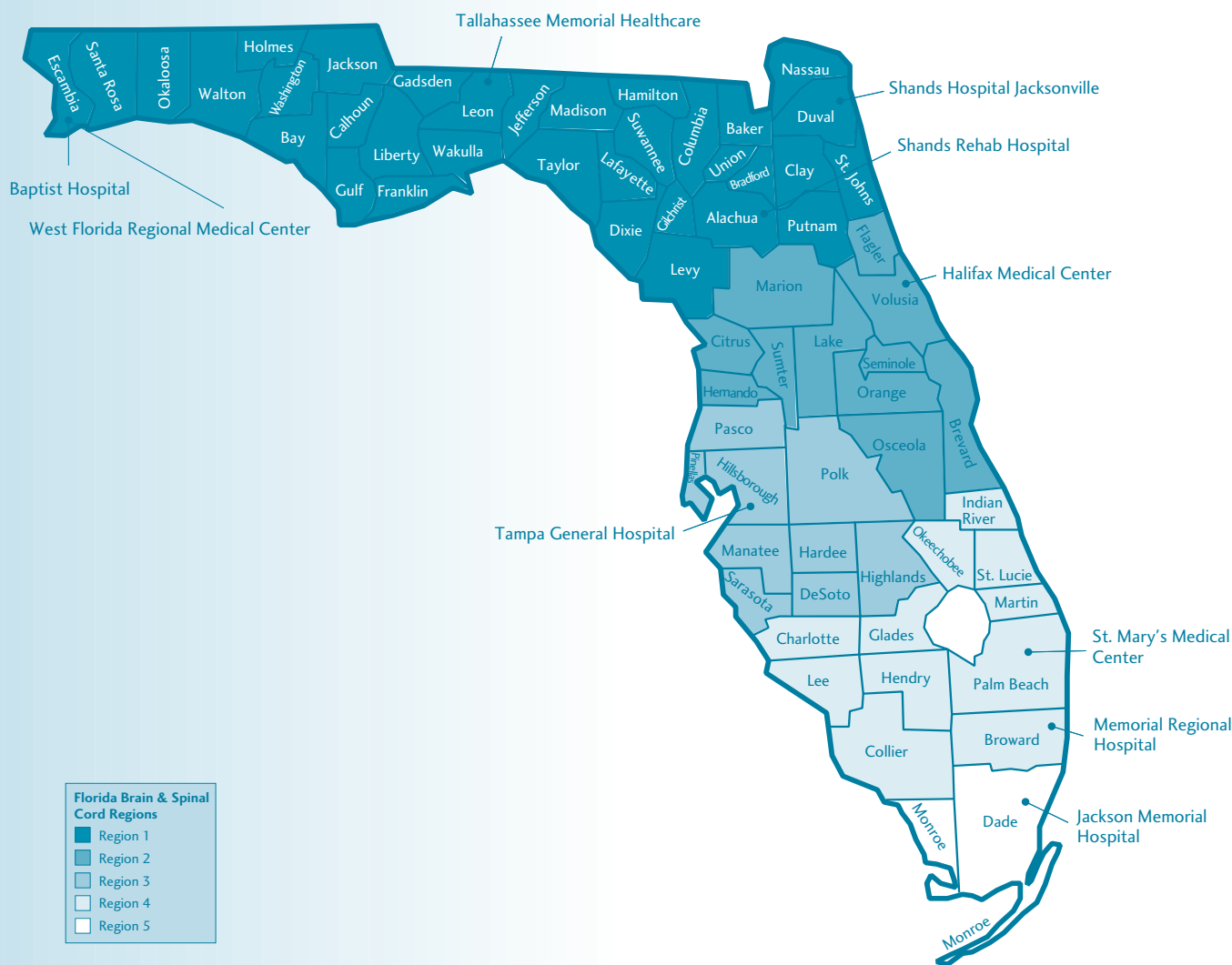
- a. A decision regarding designation.
- b. Period of time for which the designation is valid.
- c. A composite report of the observations of the site reviewers.
- d. Recommendations for improvement as a Brain and Spinal Cord Injury Program.

- e. If the organization is not recommended for designation, the report will outline the steps to be taken, should they wish to continue to pursue designation.

FLORIDA BRAIN & SPINAL CORD INJURY PROGRAM
current designated acute care brain injury facilities



FLORIDA BRAIN & SPINAL CORD INJURY PROGRAM
current designated acute care spinal cord injury facilities



Emergency Medical Services/Acute Care

Department of Health (DOH)

Emergency Medical Services is charged with the management of the brain and spinal cord injury patient at the scene of injury. Thus, management includes extrication, immobilization, and evaluation of central nervous system as well as systemic trauma. It also includes proper “on-site” 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.

1.0 Brain and spinal cord injury acute care centers

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

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 by minimizing those changes which occur on a subcerebellar and tissue level. These changes involve alterations of cerebral flow, cell membrane permeability, the release of chemicals which can furnish damage to already compromised tissue and derangements in the electrical activity of brain tissue. It has been shown that the damaged brain is highly susceptible to variations in blood pressure, oxygenation and other extra-cranial parameters. Indeed, these parameters may play as significant a role in determining the eventual outcome as do the nature and extent of the initial brain or spinal cord injury. In addition, the brain or spinal cord injured patient, because of alterations in neurological status, is at significantly high risk for the development of systemic complications which may, in turn, add further insult to the nervous system. These complications most frequently arise during the acute care phase of treatment. Experience has shown that the adop-

tion of a multi-disciplinary approach results in a reduction of morbidity and mortality. These findings lend significant support to the need for treating persons with brain or spinal cord injuries in centers which can provide the necessary personnel and material to treat these injuries both promptly and comprehensively.

Pathophysiological studies investigating blood flow, hemorrhage, swelling, histomorphology, and electrophysiology in acute brain or spinal injury have identified the first minutes and hours following trauma as the most critical interval requiring prompt, definitive, diagnostic and therapeutic intervention. Experienced investigators believe that significant brain or spinal cord damage ensues within the first few hours following injury. 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 time for numerous systemic complications. Therefore, the care afforded the patient with a brain or spinal cord injury during this period must be of the highest standards and must address pertinent aspects of care.

Acute Care Objectives

- A. To design and maintain a statewide system for acute care of new patients with brain or spinal cord injuries.
- B. To establish criteria for designation of centers capable of delivering optimal care to patients who sustain acute brain or spinal cord injury.
- C. To provide 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 medical techniques through information and education including public education on safety and prevention.
- E. To provide continuing education for EMTs, paramedics, and emergency department staff and coordinate this information and training with the multidisciplinary teams of rehabilitation centers, transitional living facilities and home-based programs.

1.1 Emergency Medical Services (EMS)

A. A brain or spinal cord injury coordinator/EMS administrator(s) who facilitates a timely and orderly transfer of patients with acute brain or spinal cord injury to and from the center must be on staff. The individual(s) will facilitate and augment essential physician communication. (The EMS coordinator will not make medical judgments, rather, this person will be involved in data collection and EMT training.)

B. Training – A comprehensive in-hospital training program must be available for the initial and continuing education of emergency technicians, EMTs, paramedics, nurses, physicians, allied health personnel and other interested groups in the hospital in the care of patients with acute brain or spinal cord injury.

C. Heliport – Heliport landing facilities should be in proximity to the emergency department and shall meet FAA and DOT requirements.

D. Communication – The brain or spinal cord injury acute center shall maintain a two-way radio communication with the ambulance/rescue vehicle. This voice radio shall be compatible with the regional EMS and SATC standard communication system.

E. Medical/Surgical Plan of Care – A plan of care must be developed to be used as a guideline for the treatment of patients with acute brain or spinal cord injury who have been accepted by the brain or spinal cord injury acute center for treatment. The plan of care shall be made available to all health providers in the catchment area. These providers shall be made aware that the center is an acute Brain and Spinal Cord Injury Program designated facility and that all patients with a newly acquired brain or spinal cord injury should be transferred to the designated facility.

1.2 Hospital Requirements

A. Must be approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

B. Develop significant experience and commitment to brain or spinal cord injury acute care. Experience in the field has indicated that a minimal standard of 100 new patients with brain injury and 24 new patients with spinal cord injury in a 24-month period should be achieved and maintained and meet the reporting requirements of the

Central Registry.

1.3 Hospital Support Capability

A. The Emergency Department (E.D.) is staffed with a qualified and designated medical director. The E.D. physicians are trained in the care of the critically ill patient with a brain or spinal cord injury and at least one E.D. physician is present in the E.D. 24 hours a day.

B. There must be on staff a designated board certified/eligible neurosurgeon responsible for patients with acute brain injury and/or a board certified/eligible orthopedist responsible for patients with spinal cord injury who has in-depth experience and spends a significant portion of time treating patients with brain or spinal cord injury.

C. The following surgical specialists shall, in the case of associated multiple injuries, be available on call and promptly available:

1. neurosurgeon
2. maxillofacial surgeon
3. oral surgeon
4. general surgeon
5. cardiac surgeon
6. trauma surgeon
7. obstetrics-gynecologic surgeon
8. otorhinolaryngologic surgeon
9. anesthesiologist
10. thoracic surgeon
11. pediatric surgeon
12. urologic surgeon
13. ophthalmic surgeon
14. radiologist
15. orthopedic surgeon

D. The following non-surgical specialists are on call and promptly available from inside or outside the hospital:

1. cardiologist
2. pulmonologist
3. gastroenterologist
4. hematologist
5. internal medicine
6. nephrologist
7. physical medicine and rehabilitation
8. pathologist
9. pediatrician
10. psychiatrist and/or neuro psychologist
11. psychologist.

E. The following facilities and personnel shall be available on call on a 24-hour basis:

1. ICU with a minimum of 4 beds available for patients with brain or spinal cord injury and staffed with personnel trained in brain or spinal cord injury acute care problems and which have the necessary equipment and personnel for brain or spinal cord injury care, including ICP monitoring.
2. x-ray department with staff for 24 hour CT scanning
3. pharmacy
4. operating room
5. recovery room
6. respiratory therapy
7. blood bank services
8. clinical lab
9. EEG/or evoked potential monitoring
10. social service
11. counseling
12. pastoral care

F. There should be a designated person responsible for reporting new admissions to the BSCIP Central Registry.

G. The following services shall be available a minimum of 5 days per week:

1. physical therapy
2. occupational therapy
3. speech therapy
4. psychiatry/neuropsychology/psychology
5. nutritional support services

H. All patients shall be referred to the Brain and Spinal Cord Injury Support Group and the peer support groups in the local region.

I. Treatment protocols for transfers of patients with brain or spinal cord injury should be established between Brain and Spinal Cord Injury Program designated centers and other hospitals to promote continuity and a smooth transfer. Telephone communication should be established between the physician in charge of the patient at the outlying hospital and the brain or spinal cord injury physician at the brain or spinal cord injury center regarding advice to supplement the treatment protocols and to effect transfers.

J. The brain or spinal cord acute care nursing service shall meet the minimum established brain and spinal cord

acute care nursing standards. (Please refer to standard 1.5 through 1.14.)

K. A brain or spinal cord injury prevention program shall be ongoing. It should include at least the following components:

1. Ongoing community awareness program that may include the local media to target specific prevention concerns.
2. Regularly scheduled brain and 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. Brain and spinal cord injured survivor to relate their personal experience with injury
3. A designated brain and spinal cord injury prevention coordinator.
4. Demonstrated involvement or collaboration with other organizations involved in prevention activities.
5. Support legislation that will influence public policy decisions to prevent brain and spinal cord injuries.
6. Familiarity with ongoing injury prevention programs and local epidemiology of injury.
7. The ability to serve as an injury prevention resource for the community.

L. The brain or spinal cord acute care psychology service shall meet the minimum established brain or spinal acute care psychology standards. (Please refer to standards 1.15 through 1.20.)

1.4 Data Collection and Evaluation

A. To ensure consistency in assessing and classifying spinal cord injuries and to ensure accurate communication between clinicians and investigators, facilities must use the “Standard Neurological Classification of Spinal Cord Injury” developed by the American Spinal Injury Association (ASIA). (Spinal Cord Acute Care Facilities only)

B. To ensure consistency in assessing and classifying brain injuries and to ensure accurate communication

between clinicians and investigators, facilities use the Glasgow Coma Scale in classifying persons with brain injury.

C. Data should be collected on an ongoing basis and manually reviewed to include the following elements:

1. number of new patients
2. length of stay and disposition
3. a monthly total quality management with documented review of morbidity and referral where care is inappropriate, and action for resolution

D. The current guidelines titled, “Guidelines for the Management of Severe Head Injury”, by American Association of Neurosurgeons AANS/BTF are available and utilized.

1.5 Brain and Spinal Cord Injury Acute Care Nursing

The standards for brain and spinal cord injury apply to nursing practice in the acute care setting. Acute care 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 care brain and spinal cord injury nursing care is patient-centered and goal-directed. Nurses assist in teaching persons with brain or spinal cord injury and their family to maximize abilities, to minimize disabilities, and to prevent complications while dealing with the myriad adjustments in their lifestyle.

Acute care brain and spinal cord injury nursing care possesses the characteristics identified by these standards so that individuals may receive high quality nursing care. Each standard is followed by rationale assessment factors. Assessment factors are used to determine the achievement of standard and serve to evaluate the nursing care the patient has received.

1.6 Brain and spinal cord injury nursing practice is based on specialized knowledge and clinical skills necessary to care for persons with brain or spinal cord injury.

Rationale – Brain and spinal cord injury often occurs in geriatric and healthy young individuals, and often affects all body systems. Nurses need relevant education and clinical experience to provide quality care for these individuals.

Assessment Factors

A. Registered nurses providing care for a person with a brain or spinal cord injury will receive a minimum of five contact hours of education per year in each specific area relating to the care of persons with brain or spinal cord injury.

B. In-services or continuing education for all nurses caring for persons with brain or spinal cord injury is provided annually to inform them about new knowledge, research and clinical procedures in reference to neuroscience practice, and pediatrics where appropriate.

1.7 The collection of data about the health status of the individuals is systematic and continuous. The data are accessible, communicated, and recorded by the interdisciplinary health care team concerned with the patient.

Rationale – Comprehensive care requires complete and ongoing collection of data about the patient by the interdisciplinary team, including nursing care needs.

Assessment Factors

A. Health status data included:

1. Physical assessment and interview
2. Clinical assessment of neurological status
3. Assessment of developmental status
4. Psychosocial and socio-economic assessment

B. Continuous collection of data is evident by frequent updating of Nursing Care Plan and/or Nursing Progress Notes.

1.8 Nursing diagnoses/problems are derived from health status data.

Rationale – The health status of the patient is the basis for determining the nursing care needs. The data are analyzed and compared to norms when possible.

Assessment Factors

A. The individual’s neurological deficits, capabilities, and limitations are identified.

B. The nursing diagnoses/problems are consistent with the diagnoses of all other professionals caring for the patients.

1.9 The plan of nursing care includes goals/

outcomes derived from the nursing diagnoses/problems.

Rationale – The determination of the goals and outcome to be achieved is an essential part of the plan of care.

Assessment Factor

A. Goals/outcomes are established to maximize functional capabilities.

1. These are congruent with other planned therapies.
2. These are stated in realistic and measurable terms.
3. These are assigned a time period for achievement.
4. The patient and/or significant other are involved, when possible, on an ongoing basis in goal development, health promotion, maintenance, and restoration.
5. These are designed to prevent secondary conditions.

1.10 Brain and spinal cord injury nursing practice is characterized by recognizing each patient and family as an individual whose unique response to injury will influence care and progress. The Plan of Nursing Care is individualized for each patient to include priorities and prescribed nursing actions that achieve the goals/outcomes derived from the nursing diagnoses and problems.

Rationale

- A. Goals/outcomes will vary according to each individual patient and family. Response and progress of each patient will vary according to certain biopsychosocial factors.
- B. Nursing actions are planned to promote, maintain, and restore the patient’s physical, emotional, social, and developmental health.

Assessment Factors

A. Consideration is given to pre-injury biopsychosocial status of each patient and family unit when establishing goals/outcomes.

1. Professional goals/outcomes are individualized to each patient and family unit consistent with the patient and family goals.
2. The right of the patient to choose limited goals is accepted, whenever possible.
3. Physiological measures are planned to prevent or control specific patient problems and secondary conditions, such as:

- a. Skin integrity
 - b. Nutrition, hydration
 - c. Elimination—bladder, bowel program
 - 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
 - h. Secondary insults to the nervous system
 - i. Spinal shock
 - j. Autonomic Dysreflexia
 - k. Pain assessments and managements
4. Psychosocial measures are planned to prevent or control specific patient/family problems as appropriate.
- a. Grief process
 - b. Loss of sensation, movement, bowel/bladder and sexual dysfunction
 - c. Financial concerns
 - d. Family participation in care
 - e. Privacy needs
 - f. Communication skills
 - g. Behavioral recognition/management
 - h. Altered mental status
 - i. Developmental issues
 - j. Community reintegration
 - k. Cultural issues and needs

1.11 Brain and spinal cord injury nursing practice and actions are characterized by an ongoing teaching/learning experience for the patient and family in conjunction with all members of the health team. Nursing actions assist the patient and family to maximize health capabilities.

Rationale

- A. Nursing actions are designed to promote, maintain, and restore health.
- B. Brain and spinal cord injury are conditions requiring continuing teaching/learning for health maintenance.

Nursing Factors

- A. Nursing actions are:
 1. Consistent with the medical plan of care
 2. Individualized to specific problems
 3. Provide a safe, therapeutic environment
 4. Involve teaching/learning opportunities

5. 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

B. Nursing actions are based upon an assessment of the patient and family biopsychosocial strengths, resources and problems as identified in the Nursing Plan of Care and daily progress notes.

1.12 The patients status toward goal achievement requires continuing assessment, evaluation of priorities, establishment of new goals, and revision of the Nursing Plan of Care.

Rationale – The Nursing Plan of Care is continually reviewed and updated to reflect changes in patient and family status.

Assessment Factors

- A. The degree of goal/outcome achievement is evaluated and reassessed continually.
- B. New goals/outcomes and approaches are developed by nursing staff with patient and family input in coordination with the interdisciplinary team.

1.13 Nursing practice is directed toward discharge planning by the integration of care with family members, and other members of the health care team for the patient's successful transfer to home, a rehabilitation facility, or other institution.

Rationale – Patients and families need to be prepared for rehabilitation efforts and the transition from the acute care setting to home, rehabilitation facility or other institution, when appropriate.

Assessment Factors

- A. Discharge planning efforts, when appropriate, are implemented on admission to the acute care facility, along with initiation and evaluation of funding resources. Admission rehabilitation plans will be established and charted within seven days.
- B. Nursing staff work in conjunction with patient/family and other members of health team and community agencies to facilitate acute care, rehabilitation, and discharge planning.

1.14 Nursing practice facilitates community awareness

of persons with brain and spinal cord injury.

Rationale – Community awareness of brain and spinal cord injury is important to reduce the incidence of brain and spinal cord injury and to promote prevention and proper emergency handling of these patients.

Assessment Factors

- A. Nursing staff participates in community awareness and prevention activities for brain and spinal cord injury, lessening of disability and cost containment and first aid/handling of persons with a brain or spinal cord injury by any of the following:
 1. Community and group lectures and in-services
 2. Participation in community planning boards and coalitions
 3. Encouraging media coverage and public service announcements
 4. Brain and spinal cord injury prevention programs
 5. Involvement with other community prevention groups
 6. Involvement with public and private school systems

1.15 Brain and Spinal Cord Injury Acute Care Psychology

The purpose of the standards in the acute setting is to manage the psychological and behavioral reactions to the traumatic injury, to promote favorable outcome from medical treatment, and maximize function in individuals with brain or spinal cord injury from a behavioral and psychological perspective. It accomplishes this task through appropriate factors that are related to the trauma of the injury, acute institutionalization, medical procedures and functional outcome, and utilizes the results of these assessments with an interdisciplinary team approach to develop an effective overall treatment plan. In addition, it provides specific behavioral and psychological interventions with individuals with brain or spinal injury, their families and significant others to maximize physical and psychological function, independence and quality of life.

1.16 Staffing

- A. There should be at least one designated clinical doctoral level licensed psychologist with expertise in brain and spinal cord injury who is identified as the psychologist with responsibility for brain and spinal cord injury service. Qualified masters level counselors with appropri-

ate credentials to provide clinical services to patients with brain or spinal cord injury may also be employed as staff in addition to the doctoral level psychologist(s). However, they must be under the supervision of the doctoral level psychologists and masters level counselors should not be greater than two masters level to one doctoral level staff. When caring for the pediatric population the psychologist should have training and experience with children.

B. The number of psychologists and counselors on staff must be sufficient to provide the necessary clinical psychological services as outlined in the psychology standards.

1.17 Training

Orientation

A. Each psychologist starting on the brain and spinal cord injury service should be provided with an orientation in at least the brain and spinal cord injury section of the following disciplines:

1. Psychology/neuropsychology
2. Physical therapy
3. Occupational therapy
4. Nursing
5. Social Work
6. Respiratory therapy
7. All medical specialties involved with patients with brain or spinal cord injury in the acute unit
8. Any other discipline involved with the acute brain and spinal cord injury service

B. The orientation should include the following:

1. Physiology and neuroanatomy, including determination of level, completeness and functional correlation and/or cognitive levels
2. Functional and/or neuropsychological assessment
3. Emotional impact and stage of psychological factors
4. Developmental assessment
5. Cognitive assessment
6. Sexual functioning
7. Family dynamics
8. Activities of daily living and care
9. Management of acute problems (see standards)
 - a. ICU procedures
 - b. Surgical procedures
 - c. Nonsurgical medical treatment
 - d. Respiratory therapy procedures

10. Goals and philosophies of the unit
11. Rehabilitation resources in the community
12. Clinical policies and procedures of each discipline
13. Treatment of interventions and strategies of each discipline

C. Each psychologist in the acute brain and spinal cord injury service should attend at least four service education or training programs on brain and spinal cord injury rehabilitation-related topics per year.

D. The psychologist on a pediatric unit should be knowledgeable and experienced in developmental processes.

1.18 Clinical Procedures

Assessment

A. Every patient with brain or spinal cord injury, and their family admitted to the acute brain and spinal cord injury center will have an assessment provided by or under the supervision of the psychologist as soon as practically possible, but no later than four days. This assessment at minimum should include the following:

1. Psychological status of the patient and family
2. Behavioral reactions of the patient and family
3. Premorbid psychological, behavioral and educational/work status
4. Recommendations for maximizing acute care outcome and potential for rehabilitation
5. Identification of any anticipated cognitive, psychological or behavioral problems
6. Treatment plan

B. Neuropsychological and Psychological Testing – The type and frequency of neuropsychological testing should be provided as deemed clinically warranted and appropriate for the acute care setting.

C. Treatment Plan – A psychology treatment plan, including current psychological status, goals of the treatment intervention provided, and response to the treatment, should be developed after the assessment and updated appropriately.

D. Treatment Interventions – Treatment interventions should be made available to the acute patients with brain and spinal cord injury and family as deemed clinically appropriate. No delineation of services should be included here.

E. Discharge Summary – There should be a psychological discharge summary for each patient which should include the following:

1. Premorbid psychological behavioral, and education/work status
2. Initial cognitive, behavioral and psychological status
3. Treatment intervention provided
4. Current cognitive, behavioral and psychological status
5. Recommendations
6. Status of family adjustment

F. Post Acute Care – The acute brain and spinal cord injury psychology service should take responsibility for patient and family follow-up after discharge by either providing periodic assessment and outpatient services as needed or appropriate consultation with agency to which patient and family is being referred.

1.19 Documentation

A. The following must be documented in the patient chart:

1. Initial neuropsychological and psychological assessment
2. Results of any neuropsychological and psychological testing
3. Psychological and cognitive treatment plan updated appropriately
4. Progress notes for patients undergoing psychological and neuropsychological treatment per intervention
5. Discharge summary including status of family adjustment

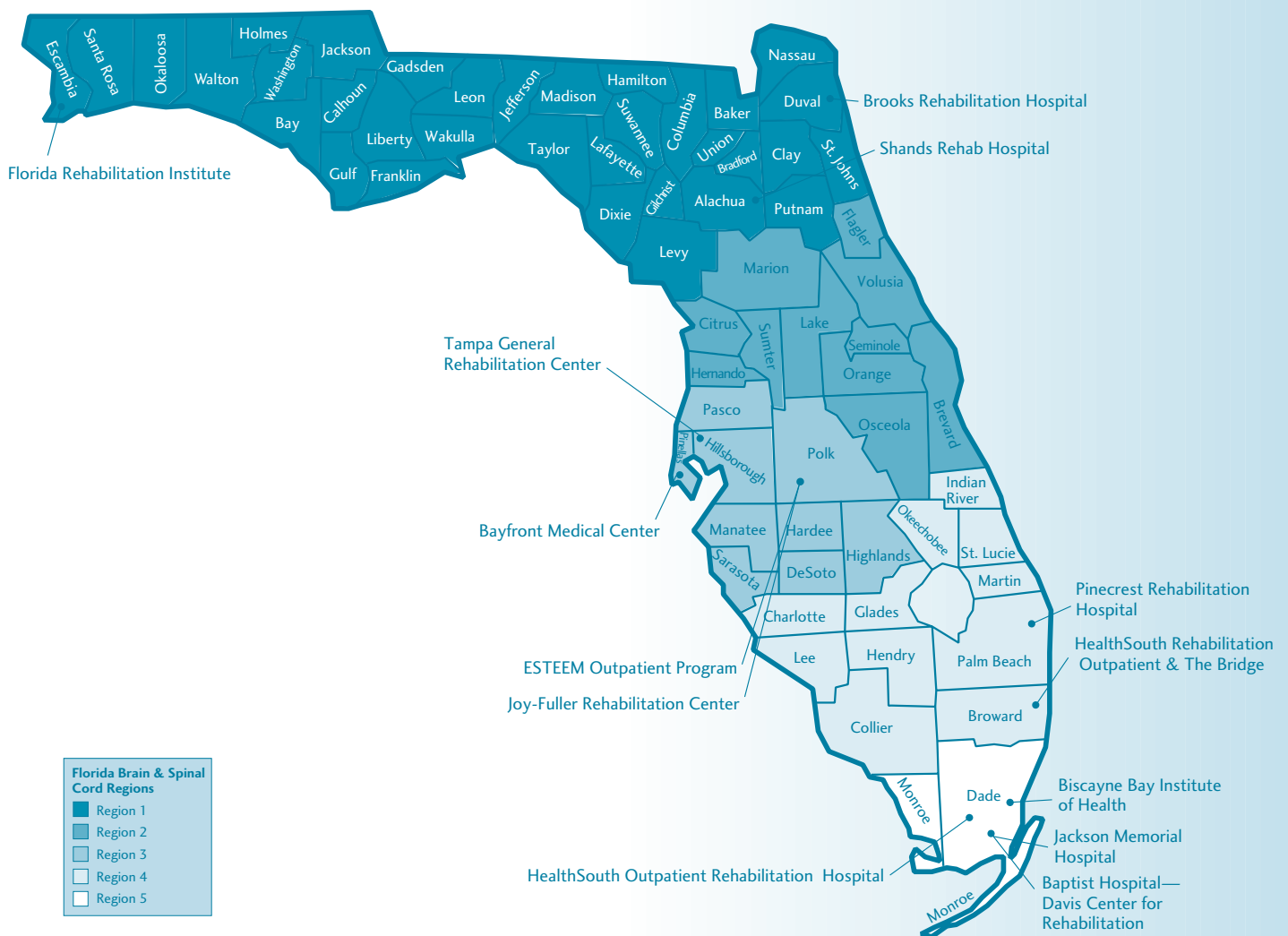
1.20 Interdisciplinary Collaboration

A. The psychology services must be provided as part of an integrated interdisciplinary team approach. Each psychologist on the brain and spinal cord injury service should be involved with the following:

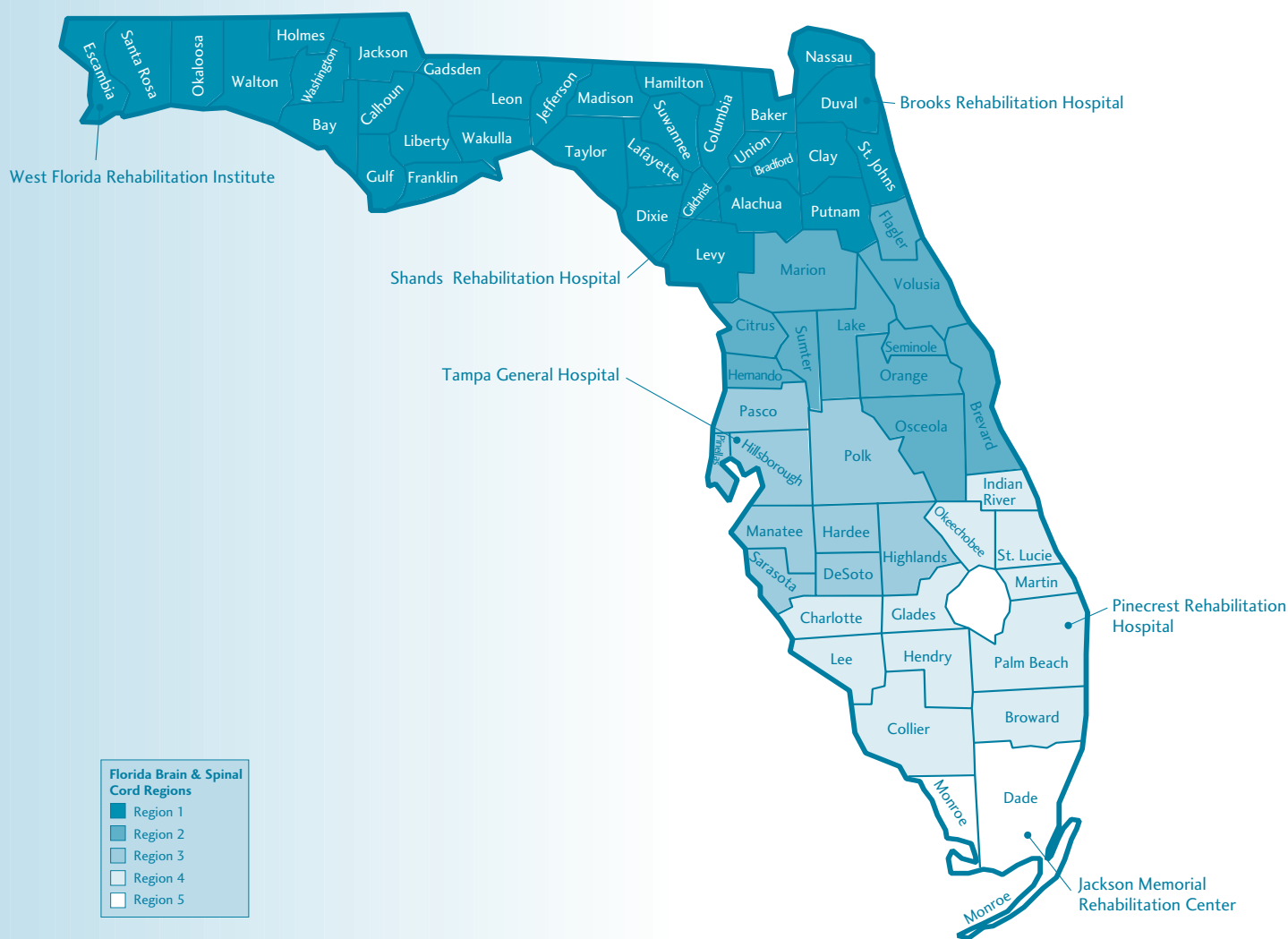
1. Attend team meetings or rounds
2. Attend and participate in patient/family conference when possible

3. Consult with each discipline involved with the patient and family as needed for the purpose of maximizing functional outcome from a cognitive behavioral and psychological perspective
4. Coordinate with any psychiatric consultation or treatment being provided to the patient and family
5. Makes every effort to provide services to patient and family where there are communication barriers, i.e., foreign languages, deafness, tracheostomies.

FLORIDA BRAIN & SPINAL CORD INJURY PROGRAM
**current designated inpatient/outpatient brain injury
 rehabilitation facilities**



FLORIDA BRAIN & SPINAL CORD INJURY PROGRAM
**current designated inpatient spinal cord injury
 rehabilitation facilities**



2.0 Adult Brain and Spinal Cord Injury Rehabilitation Facilities

Rehabilitation refers to those events and processes occurring after injury and progressing to ultimate stabilization and maximum possible recovery. This complex care is provided in a rehabilitation facility capable of managing recent injury, comprehensive medical, social, psychological and developmental complications. Administrative uniqueness provides for a separate allocation of brain and spinal cord injury beds with a comprehensive trained staff integrated with both the acute care phase and post discharge living facilities. Services available include medical/physical restoration, physical and occupational therapy, specialized nursing, family services, recreational therapy, psychological counseling and education of both patient and family in addition to vocational reeducation or school reintegration.

Referral and transfer to a rehabilitation center usually comes from several acute sources. Early referral to and initiation of a rehabilitation program in a comprehensive rehabilitation center has been documented to result in more independence earlier for a patient with brain or spinal cord injury, with fewer complications at a considerable savings, both economically and emotionally.

Coordination with acute care centers ensures this efficient and smooth transfer. Care extends beyond the initial admission and must be directed towards developing a satisfactory lifetime program with monitoring, reevaluation, upgrading inpatient performance, and early detection of potential complications.

Rehabilitation Objectives

A. Individuals with brain and/or spinal cord injuries will have available the highest quality inpatient rehabilitation program possible.

B. Individuals with brain and/or spinal cord injuries will be rehabilitated to optimal independence within the context of an inpatient rehabilitation program.

C. Develop a system of adult and pediatric inpatient rehabilitation centers with expertise in providing optimal comprehensive care for persons with brain or spinal cord injury and their families.

D. Provide a continuum of care by developing an efficient referral pattern between system components with appropriate documentation of services.

2.1 The licensed rehabilitation hospital shall be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) in Comprehensive Rehabilitation. [In addition, as a minimum, CARF accreditation will be required in the areas of: a) brain injury/spinal cord injury program,] and b) [vocational development or an agreement with a CARF accredited vocational development program in the community. A written agreement with the community vocational development program is necessary.] Accreditation in other program areas is encouraged, but not required.

2.2 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 beds and/or 30 inpatient new admissions annually is required to maintain a viable inpatient rehabilitation Brain Injury Center. A minimum of 40 spinal cord injury admissions is required annually to maintain a viable inpatient rehabilitation Spinal Cord Injury Center. For inpatient Spinal Cord Injury Centers, up to 25 percent may include non-traumatic paralysis patients resulting from acute vascular complications, iatrogenic causes, or acute transverse myelitis.

2.3 The inpatient rehabilitation center program medical director shall be a physician who has evidence of, training, knowledge and experience of the rehabilitation of patients admitted to the specific specialty programs; that is, specialized training and experience in brain injury rehabilitation for designated brain injury rehabilitation centers and specialized training and experience in spinal cord injury rehabilitation for designated spinal cord injury rehabilitation centers.

2.4 Rehabilitation services should be initiated within the intensive care setting, where possible, and extend throughout the course of recovery. In addition, each accredited inpatient rehabilitation facility will make available to the referring facilities in their catchment area, a person with specialized training to evaluate a patient with a brain or spinal cord injury regarding recommendations for inpatient rehabilitation care. It shall also provide ongoing clinical consultation upon request of the institution.

2.5 The rehabilitation program should have a formalized agreement with, or be part of, an inpatient hospital within its catchment area. Each rehabilitation facility will provide written policies which establish criteria for admission and specific patient information from referring sources. These written policies should be distrib-

uted to all potential referral sources.

2.6 There should be specifically designated beds for the rehabilitation of persons with brain and 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.

2.7 There should be a designated injury coordinator for brain injury and a designated injury coordinator for spinal cord injury for rehabilitation care whose responsibilities will include: a) facilitating referrals and admissions to the rehabilitation center, as well as transfers to and from acute facilities; b) disseminating of information to related agencies and institutions; c) liaison with state agencies and insurance companies, and d) coordinating disaster relief with county and state emergency management officials.

2.8 The facility must be a subscriber of the Uniform Data System/Functional Independent Measure data collection system.

2.9 There should be a designated person responsible for reporting new admissions to the BSCIP Central Registry.

2.10 There should be a formalized discharge plan and an established process of ongoing contact with third party payors and relevant public and community agencies to ensure continuity of care.

2.11 Team members from the professional disciplines with special interest, training, experience, and expertise as described in the CARF brain and spinal cord injury standards must be included as staff of the center. In addition, medical consultive services need to be available. These should include, but not be limited to:

1. Physical medicine and rehabilitation
2. Neurosurgery
3. Orthopedic surgery
4. Neurology
5. Internal medicine/infectious disease
6. Ophthalmology
7. Otorhinolaryngology
8. General surgery
9. Reconstructive surgery
10. Urology
11. Psychiatry
12. Pediatrics

2.12 Based on individual needs, the program should have or make formal arrangements for the provision of the following services:

1. Respiratory therapy
2. Vocational services
3. Audiology
4. Dentistry
5. Orthotics/prosthetics
6. Dietetic/nutrition
7. Education, i.e., local school boards, home bound teachers
8. Drivers evaluation and training/certified (see 2.27)
9. Pharmacy

2.13 Rehabilitation centers should meet the minimum standards for brain and spinal cord injury rehabilitation nursing. (Please refer to standards 2.28 through 2.38.)

2.14 Rehabilitation centers should meet the minimum standards for brain and spinal cord injury psychology. (Please refer to standards 2.39 through 2.46.)

2.15 Diagnostic services should be available or readily accessible on a referral basis including:

1. Electro-diagnostic services, including EEG, EMG, and evoked potentials, brain stem auditory evoked response, etc.
2. Radiological services, including CT SCAN and MRI
3. Laboratory services
4. Urodynamics

2.16 An initial informal interdisciplinary assessment should be performed on each patient within the first two weeks of admission and updated at least every two weeks. These assessments should address the following, but not be limited to:

1. Medical status
2. Developmental status
3. Psychosocial 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 capacity
8. Communication capacity
9. Behavioral status
10. Swallowing
11. Activities of daily living skills
12. Recreation and leisure time skills
13. Education and/or vocational employment potential

14. Sexuality
15. Community reintegration, including appropriate post-discharge services. A formal interdisciplinary assurance and plan must be in place prior to discharge.
16. Environmental modification

2.17 The facility must have policy and procedures stating the determination of legal competency issues and status.

2.18 An integrated interdisciplinary treatment plan should be developed and continually revised based on patient status which should include, but not be limited to, the following:

1. Medical management
2. Behavioral management program
3. Cognitive retraining program
4. Family counseling/therapy
5. Speech therapy
6. Psychological services
7. Physical therapy
8. Occupational therapy
9. Rehabilitation nursing
10. Therapeutic recreation
11. Functional daily living skills training
12. Community reintegration skills training
13. Social skills training
14. Sexual functioning education and training

2.19 In addition to the items to be provided in the written follow-up plan of care as delineated by the CARF standards, the patient, family and/or significant other should be provided with information regarding available options for follow-up care, community services, and/or alternative programs.

2.20 The rehabilitation center must establish a formal transfer agreement with designated licensed transitional living facilities and other appropriate community based programs to ensure smooth transition back into the community.

2.21 The rehabilitation center shall have the capability of transporting patients who use wheelchairs. The emphasis of the transportation utilization should be for recreational and social activities.

2.22 The rehabilitation center shall provide a multipurpose group room for social, vocational, educational, and other group meetings as appropriate.

2.23 Access to a leisure/recreational area proximal to the rehabilitation center should be provided.

2.24 A communal dining/eating room must be in the facility.

2.25 The rehabilitation center shall utilize educational information as developed by the state Brain and Spinal Cord Injury Program and Resource Centers and be an integral part of the program.

2.26 A brain and spinal cord injury prevention program shall be ongoing. It should include at minimum the following components:

1. Ongoing community awareness program that may include the local media to target specific prevention concerns
2. Regularly scheduled brain 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. Brain or spinal cord injured survivor to relate their personal experience with injury
3. A designated brain and spinal cord injury prevention coordinator
4. Demonstrated involvement or collaboration with other organizations involved in prevention activities
5. Support legislation that will influence public policy decisions to prevent brain and spinal cord injuries
6. Familiarity with ongoing injury prevention programs and local epidemiology of injury
7. The ability to serve as an injury prevention resource for the community

2.27 The rehabilitation facility shall meet the Brain and Spinal Cord Injury Program guidelines for facilities providing disabled driver training and prescriptions for adaptive equipment.

2.28 Brain and Spinal Cord Rehabilitation Nursing
 Rehabilitation brain and spinal cord nursing is a sub-specialty of rehabilitation nursing. Rehabilitation brain and spinal cord nurses diagnose and treat human response of individuals with brain or spinal cord injury or disease which interrupts functions and alters life satisfaction. This

nursing care is goal-directed and patient and family centered. The goals of brain and spinal cord nursing are to teach the individual and family to maximize abilities, minimize disabilities, and prevent complications in order that the individual and family may regain control in the management of health.

Objectives

The objectives of brain and spinal cord injury nursing care in the rehabilitation setting are:

A. To provide the highest quality of nursing care by:

1. Minimizing preventable complications through patient and family education
2. Maximizing patient's abilities and family and caregiver strengths
3. Enabling the individual and family to assume responsibilities for health management

B. To promote continuity of care prior to admission through discharge and post hospitalization.

C. To educate other health care providers about rehabilitation concepts.

D. To promote community awareness of brain and spinal cord injury:

1. Through prevention programs
2. By advocating for mandates established in the Americans With Disabilities Act
3. By promoting the inclusion of individuals with brain and spinal cord injury in the community

2.29 Staffing

A. The rehabilitation center shall provide care which is supervised 24 hours per day by a registered nurse skilled in the care of brain and/or spinal cord injured patients. The nurse will be a CRRN or will attend and document at least five CEU hours a year in rehabilitation nursing.

B. The nursing care of each patient shall be directed by a registered nurse skilled in brain and/or spinal cord injury nursing.

C. The rehabilitation center shall provide brain and/or spinal cord injury nursing 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.

D. The rehabilitation nurse shall participate as a member of the interdisciplinary team as evidenced by:

1. Rehabilitation committees
2. Interdisciplinary conferences and meetings
3. Interdisciplinary therapeutic activities such as patient group sessions

E. Rehabilitation centers serving pediatric rehabilitation programs will have nurses knowledgeable and experienced in the care of children with brain or spinal cord injury, and their family.

2.30 Training and Education

A. The rehabilitation center shall provide a formal orientation program for all nursing staff who are to care for patients with brain and/or spinal cord injury. This orientation program shall address specifics of care, including, but not limited to:

1. Human dignity and emotional needs
2. Stages of human development
3. Effects of immobility
4. Bowel and bladder management
5. Skin care
6. Human sexuality
7. Complications and secondary conditions
8. Cognitive levels
9. Emergency interventions and management of acute problems
10. Behavior management
11. Safety
12. Neurological assessment
13. Family/patient education
14. Effective staff/family communication
15. Psychological adjustment
16. Autonomic Dysreflexia
17. Recreation and leisure activities
18. Stress management
19. Family dynamics including signs and symptoms of dysfunction, coping styles and appropriate intervention.

B. 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 brain injury should be presented at least quarterly.

C. There shall be brain and spinal cord injury resource

materials available to the nursing staff. These resources should include professional journals, books, articles, and audiovisual materials.

D. There is evidence of cross training in rehabilitation of nurses from other units or areas within the center being utilized.

E. The nurses' competence shall be evaluated at specific intervals.

G. There shall be policies and procedures specific to brain and/or spinal cord injury nursing care, including, but not limited to:

1. Bowel and bladder management
2. Orthotic and prosthetic care (i.e. halo)
3. Neurological assessment
4. Skin care
5. Body mechanics and transfer techniques
6. Turning and positioning
7. Provisions of emergency care
8. Safety
9. Autonomic Dysreflexia
10. Management of the agitated/aggressive patient
11. Mechanism for nurses to manage patients who abuse substances

2.31 Nursing Process

A. The pre-admission screening process/assessment shall involve a registered nurse.

B. 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.

C. There shall be uniform documentation of a nursing assessment which includes:

1. Biophysical factors
2. Psychosocial status
3. Age appropriateness
4. Cognitive-communicative status
5. Functional skills
6. Vocational-education status
7. Comfort measures
8. Cultural factors
9. Support systems
10. Identified patient/family goals
11. Other associated factors

12. Nursing diagnosis or problem list

2.32 Planning

A. There is evidence of patient/family involvement in the RN-initiated plans of care.

B. The plan of care reflects the nursing diagnosis or problems and goals expressed in measurable terms with expected dates of accomplishments.

C. The plan reflects the following:

1. Bowel and bladder needs
2. Skin care
3. Patient/family education
4. Promotion of self-care
5. Psychosocial/sexual concerns
6. Early discharge planning
7. Cognitive, perceptual deficits

D. The plan is initiated within 24 hours of admission.

E. There is documentation that the plan is reviewed and updated at least weekly.

2.33 Intervention

A. 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.

B. Interventions shall be specific to the plan of care and emphasize actions in the following areas, but not be limited to:

1. Promotion of self-care
2. Promotion of appropriate developmental status
3. Maintenance of body function
4. Prevention of complications
5. Management of emergencies
6. Management of behavioral changes
7. Coping and adjustment
8. Environmental safety
9. Discharge planning

C. The brain and spinal cord injury rehabilitation nurse shall adjust the teaching program as needed to accommo-

date cultural and educational differences of the individual patient and family.

D. There shall be documentation of the teaching done, the methodology used, and the measurement of learning.

2.34 Evaluation

A. The brain and spinal cord injury rehabilitation nurse shall evaluate the effectiveness of care planning and document patient progress at least weekly.

B. There shall be a mechanism for patients and/or families to participate in evaluating nursing care.

2.35 Interdisciplinary Collaboration

A. 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.

2.36 Program Development/Research

A. The rehabilitation center promotes opportunities for schools of nursing to incorporate clinical rehabilitation nursing in their curricula by providing a practice setting for students.

B. The rehabilitation center shall provide opportunities for the brain and spinal cord injury rehabilitation nurse to participate in related research.

C. Rehabilitation nurse(s) shall have input into major program changes which may impact on brain and spinal cord injury care.

2.37 Environmental Safety

A. The nursing staff shall be responsible for maintaining a clean and safe environment on the patient care unit. There shall be adequate equipment, emergency supplies, and linen available for the nursing staff.

B. There shall be a mechanism in place for the nurse to manage patients who abuse alcohol or drugs.

C. Rehabilitation nurse(s) shall participate in the center’s disaster preparedness process.

D. There shall be opportunities for the brain and spinal cord injury rehabilitation nurse to be involved in the center’s planning of new construction or reconstruction of areas where patients with brain and spinal cord injury will be placed.

2.38 Health Promotion in the Community

A. The rehabilitation center provides opportunities for nurses to participate in programs to educate the public on brain and spinal cord injury prevention.

Brain and Spinal Cord Injury Inpatient Rehabilitation Psychology Standards

The Psychology Standards promote quality psychological services that identify and make available specific behavioral, psychological, and cognitive interventions with patients, families and significant others in order to maximize physical, psychological, and cognitive functions and adaptations, independence, and quality of life. This is accomplished through appropriate assessment of behavioral, psychological, and cognitive factors which are related to functional outcome; and utilizes the results of these assessments with an interdisciplinary team approach to develop an effective rehabilitation plan and specific treatment interventions.

2.39 Staffing

A. There is at minimum one designated clinical doctoral level licensed psychologist with expertise in brain injury whose primary responsibility is the Brain Injury Service. There is at minimum one designated clinical doctoral level licensed psychologist with expertise in spinal cord injury whose responsibility is the Spinal Cord Injury Service. These qualifications include three years experience with brain and spinal cord injury populations and memberships in appropriate professional organizations.

B. Qualified masters level counselors with appropriate credentials to provide clinical services to patients with brain and spinal cord injuries may also be employed in addition to the doctoral level psychologist(s). The ratio of masters level counselors to psychologists does not exceed two to one. The number of psychologists and counselors on staff must be sufficient to provide the necessary clinical psychological services as outlined in the Psychology Standards. When caring for a pediatric population, the psychologist should have training and experience with children.

2.40 Training

A. Each psychologist in the Brain and Spinal Cord Injury Service is provided with an orientation in the following disciplines:

1. Administration
2. Psychology
3. Physical therapy
4. Occupational therapy
5. Nursing
6. Social work
7. Therapeutic recreation
8. Speech language/pathology
9. Vocational rehabilitation
10. Medicine
11. Any other discipline involved in the Brain or Spinal Cord Injury Service

B. The staff orientation includes the following:

1. Brain behavior relationships
2. Sequelae of brain injury or spinal cord injury
3. Functional assessment
4. Physiology and neuroanatomy, including physical impairments, functional correlations and cognitive deficits
5. Emotional impact and stages
6. Cognitive assessments
7. Sexual functioning
8. Activities of daily living and care
9. Management of acute problems (e.g., agitation, depression, confusional states)
10. Family issues
11. Neurodiagnostic test (e.g., MRI, EEG and CAT scans)
12. Goals and philosophies of the centers
13. Community resources
14. Clinical policies and procedures of each discipline
15. Treatment interventions and strategies of each discipline
16. Rehabilitation process
17. Other disciplines involved in the Brain or Spinal Cord Injury Service

C. Each psychologist on the Brain or Spinal Cord Injury Service will attend and document at least four training or continuing education credits per year on rehabilitation-related issues.

D. The psychologist on the pediatric unit should be knowledgeable and experienced in developmental processes.

2.41 Clinical Procedures

A. Assessment – Every patient with a brain or spinal cord injury admitted to the center for rehabilitation (and their family) will have a comprehensive assessment provided by the psychologist within the first two weeks of admission. This assessment, culminating in a written treatment plan, must address the following:

1. Psychological status of patient and family
2. Behavioral status of patient and family
3. Cognitive status of patient
4. Premorbid psychological behavioral and education/work status
5. Suggestions for maximizing rehabilitation outcome
6. Identification of any anticipated psychological, behavioral, or cognitive problems
7. Treatment plan

B. Psychological Testing – Psychological testing is provided as deemed clinically necessary by the psychologist. Such testing includes, but is not limited to:

1. Neuropsychological testing
2. Personality testing
3. Intelligence testing
4. Pre-vocational testing
5. Education testing

C. Treatment Plan – A psychology treatment plan that includes current psychological, behavioral, and cognitive status, goals of treatment, interventions being provided, and response to interventions is developed after the initial assessment and updated at least twice monthly.

D. Treatment Interventions – Treatment interventions are available to patients with brain or spinal cord injury as deemed clinically appropriate by the psychologist. These treatment interventions include, but are not limited to:

1. Individual psychotherapy
2. Group psychotherapy
3. Family management
4. Behavioral management
5. Cognitive remediation
6. Sexual counseling
7. Marital counseling
8. Pre-vocational counseling
9. Pain management
10. Assertiveness training
11. Stress management
12. Play therapy
13. Parent training

E. Discharge Summary – There is a psychology discharge summary for each patient which includes:

1. Premorbid psychological, behavioral and educational/work status
2. Initial behavioral, cognitive, and psychological status
3. Treatment intervention provided
4. Response to treatment
5. Current behavioral, cognitive, and psychological status
6. Functional capabilities
7. Estimated functional potential
8. Recommendations

F. Outpatient Follow-up – The brain or spinal cord injury psychologist will be responsible for patient and family follow-up after discharge by either providing periodic assessment and outpatient treatment as needed or referring the patient and family to appropriate and qualified outpatient psychological services.

2.42 Documentation

The following must be documented in the patient's chart:

1. Initial psychology assessment
2. Results of psychological testing
3. Psychology treatment plan updated bi-monthly
4. Progress notes for patients undergoing psychology treatment at least weekly
5. Psychology discharge summary
6. Outpatient follow-up contacts

2.43 Interdisciplinary Collaboration

The psychology services are provided as part of a well-integrated interdisciplinary team approach. As such, each psychologist in the Brain and Spinal Cord Injury Service participates in the following:

1. Attends and participates in interdisciplinary clinical team meetings.
2. Attends and participates in patient/family conferences.
3. Consults with each discipline involved with the patient and family as needed for the purpose of maximizing functional outcome from a behavioral, cognitive and psychological perspective.
4. Coordinates with any psychiatric consultation or treatment being provided to the patient and family.
5. Makes every effort to provide services to patients and family where there are communication barriers, i.e., foreign languages, deafness, tracheostomies.
6. Conducts family education and support groups.

7. Coordinates with the physician and other consultations as necessary.
8. Provides continuing education concerning the neuro-behavioral consequences of a brain injury to all departments.

2.44 Prevention

Psychologists participate in ongoing brain and spinal cord injury prevention as applicable.

2.45 Program/policy development

Psychologists in the Brain and Spinal Cord Injury Service should be involved in program and policy development, especially where it involves patients with brain or spinal cord injury.

2.46 Quality Assurance

Psychologists in the brain and spinal cord injury service should participate in quality assurance activities.

2.47 THE FOLLOWING ABBREVIATED STANDARDS APPLY TO FACILITIES WHO ARE CARF ACCREDITED IN THE SPECIFIC AREA OF SPINAL CORD INJURY, BRAIN INJURY OR BOTH.

2.48 INTRODUCTION

Brain and Spinal Cord Injury Rehabilitation Facilities Rehabilitation refers to those events and processes occurring after injury and progressing to ultimate stabilization and maximum possible recovery. This complex care is provided in a rehabilitation facility capable of managing recent injury, comprehensive medical, social, psychological and developmental complications. Administrative uniqueness provides a separate allocation of brain and spinal cord injury beds with a comprehensive trained staff integrated with both acute care phase and post discharge living facilities. Services available include medical/physical restoration, physical and occupational therapy, specialized nursing, family services, recreation therapy, psychological counseling and education of both patient and family in addition to vocational reeducation or school reintegration.

Referral and transfer to a rehabilitation center usually comes from several acute sources. Early referral to and initiation of a rehabilitation program in a comprehensive rehabilitation center has been documented to result in more independence earlier for a patient with brain or

spinal cord injury, with fewer complications at a considerable savings, both economically and emotionally. Coordination with acute care centers ensures this efficient and smooth transfer. Care extends beyond the initial admission and must directed towards developing a satisfactory lifetime program with monitoring, reevaluation, upgrading inpatient performance and early detection of potential complications.

Rehabilitation Objectives

- A. Individuals with brain and/or spinal cord injuries will have available the highest quality inpatient rehabilitation program possible.
- B. Individuals with brain and/or spinal cord injuries will be rehabilitated to optimal independence within the context of an inpatient rehabilitation program.
- C. Develop a system of adult and pediatric inpatient rehabilitation centers with expertise in providing optimal comprehensive care for persons with brain or spinal cord injury and their families.
- D. Provide a continuum of care by developing an efficient referral pattern between system components with appropriate documentation of services.

2.49 The Commission on Accreditation of Rehabilitation Facilities (CARF) shall accredit the licensed Rehabilitation Center. In addition, as a minimum, CARF accreditation will be required in the areas of: a) brain injury/spinal cord injury programs and b) vocational development or an agreement with a CARF accredited vocational development program in the community. A written agreement with the community vocational development program is necessary. Accreditation in other program areas is encouraged, but not required.

2.50 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 beds and/or 30 inpatient new admissions annually is required to maintain a viable inpatient rehabilitation Brain Injury Center. A minimum of 40 spinal cord injury admissions annually is required to maintain a viable inpatient rehabilitation Spinal Cord Injury Center. For inpatient Spinal Cord Injury Centers, up to 25 percent may include non-traumatic paralysis patients resulting from acute vascular compli-

cations, iatrogenic causes or acute transverse myelitis.

2.51 The rehabilitation program should have a formalized agreement with, or be a part of, an acute care hospital within its catchment area. Each rehabilitation facility will provide written policies, which establish criteria for admission and specific patient information from referring sources. These written policies should be distributed to all potential referral sources.

2.52 There should be an individual identified by the organization for brain injury and for spinal cord injury rehabilitation care whose responsibilities will include: a) facilitating referrals and admissions to the rehabilitation center, as well as transfers to and from acute facilities. b) coordinating disaster relief efforts with county and state Emergency Management officials.

2.53 The facility must be a credential subscriber to the UDS/FIM data collection system.

2.54 There should be a designated person(s) responsible for reporting new admissions to the DOH/BSCIP Central Registry.

2.55 Team members and appropriate medical specialists from the professional disciplines with special interest, training experience and expertise as described in the CARF brain and spinal cord injury standards must be included as staff of the center. In addition, medical consultative services need to be available. These should include, but not be limited to:

1. Physical medicine and rehabilitation
2. Neurosurgery
3. Orthopedic Surgery
4. Neurology
5. Internal medicine/infectious disease
6. Ophthalmology
7. Rhinology
8. General surgery
9. Reconstructive Surgery
10. Urology
11. Psychiatry
12. Pediatrics

2.56 Rehabilitation centers should meet the minimum standards for brain & spinal cord injury rehabilitation nursing. (Please refer to standards 2.67 through 2.69)

2.57 Rehabilitation centers should meet the minimum standards for brain & spinal cord injury psychology. (Please refer to standards 2.70 through 2.72)

2.58 Diagnostic services should be available or readily accessible on a referral basis, including:

1. Electro-diagnostic services, including EEG, EMG, and evoked potentials, brain stem auditory evoked response, etc.
2. Radiological services, including CT SCAN and MRI.
3. Laboratory services
4. Urodynamics

2.59 An initial informal interdisciplinary assessment should be performed on each patient within the first two weeks of admission and updated at minimum every two weeks. These assessments should address the following, but not be limited to:

1. Medical status
2. Developmental status
3. Psycho social 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 capacity
8. Communication capacity
9. Behavioral status
10. Swallowing
11. Activities of daily living
12. Recreation and leisure time skills
13. Education and/or vocational employment potential
14. Sexuality
15. Community reintegration, including appropriate post discharge services. A formal interdisciplinary assurance and plan must be in place prior to discharge
16. Environmental modification

2.60 The facility must have a policy and procedures stating the determination of legal competency issues and status.

2.61 The Rehabilitation Center must establish a formal transfer agreement with designated licensed transitional living facilities and other appropriate community-based programs to ensure smooth transition back into the community.

2.62 The Rehabilitation Center shall have the capacity of transporting patients who use wheelchairs. The emphasis of the transportation utilization should be for recreational, vocational and social activities.

2.63 The Rehabilitation Center shall provide an appropriate multi purpose group room that could be utilized for the following areas:

1. Social group meetings
2. Vocational group meetings
3. Educational group meetings
4. Leisure/recreational area
5. Communal dining facility

2.64 The Rehabilitation Center shall utilize educational information as developed by the state Brain and Spinal Cord Injury Program and be an integral part of this program.

2.65 Brain or spinal cord injury prevention shall be ongoing. It should include at minimum the following components:

1. Ongoing community awareness program(s) that may include the local media to target specific prevention concerns.
2. Regularly scheduled brain or spinal cord 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. Brain of spinal cord injured survivor to relate

their personal experience with injury.

3. A designated brain and spinal cord injury prevention coordinator
4. Demonstrated involvement or collaboration with other organizations involved in prevention activities
5. Support legislation that will influence public policy decisions to prevent brain and spinal cord injuries
6. Familiarity with ongoing prevention programs and local epidemiology of injury the ability to serve as an injury prevention resource for the community.
7. The psychologist should participate in ongoing brain and spinal cord injury prevention where applicable.

2.66 The rehabilitation facility shall meet the National Standard for facilities providing disabled driver training and prescriptions for adaptive equipment.

2.67

There shall be a mechanism in place for the nurse to manage patients who abuse alcohol or drugs.

2.68

1. Rehabilitation nurse(s) shall participate in the Center's disaster preparedness process.
2. There shall be opportunities for the brain and spinal cord injury nurse to be involved in the Center's planning of new construction or reconstruction of areas where patients with brain or spinal cord injuries will be placed.

2.69

The Rehabilitation Center provides opportunities for nurses to participate in programs to educate the public in brain and spinal cord injury prevention.

ADDENDUM INPATIENT REHABILITATION PSYCHOLOGY STANDARDS IN ADDITION TO THE COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES STANDARDS INCLUDING BUT NOT LIMITED TO PROGRAM SPECIFIC STANDARDS FOR SPINAL CORD CARE AND/OR BRAIN INJURY CARE

2.70 INTRODUCTION

The Psychology Standards promote quality psychological services that identify and make available specific behavioral, psychological, and cognitive interventions with patients, families and significant others in order to maximize physical, psychological, and cognitive func-

tions and adaptations, independence, and quality of life. This is accomplished through appropriate assessment of behavioral, psychological, and cognitive factors, which are related to functional outcome; and utilizes the results of these assessments with a interdisciplinary team approach to develop an effective rehabilitation plan and specific treatment interventions.

2.71

The Interdisciplinary Team should be involved in program and policy development, especially where it involves brain and spinal cord injured patients.

2.72

Psychologist on the Brain and Spinal Cord Injury Service should participate in Quality Service.

3.0 Adult Brain Injury Outpatient Rehabilitation Center

3.1 A Brain Injury Outpatient Rehabilitation Center is a goal oriented, interdisciplinary, outpatient therapy program specifically designed to improve the physical, cognitive, communicative, behavioral, psychological, and/or social functioning of individuals with brain injury. This program may be free standing or a component of another rehabilitation facility. The Brain Injury Center's primary patient population must be brain injured with a caseload of at least ten clients ongoing per year, and/or 100 outpatient contact hours per week.

3.2 Standards for Admission to the Brain Injury Outpatient Rehabilitation Center should include the following:

1. The client is brain injured
2. The client 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 client can benefit from rehabilitation efforts
4. The client should be manageable within the staffing limitations of the center
5. The client should have no major medical condition that precludes attendance and/or participation in the program
6. The center should make formal requests for pertinent medical and educational records

3.3 The Brain Injury Outpatient Rehabilitation Center

should offer, either by the program or through consultation arrangements, the following:

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
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. Client screening and evaluation procedures
13. Development of an individualized treatment plan for each client outlining goals and methods to achieve each goal
14. Anticipated time frames for the accomplishment of client 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

3.4 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 procedures
4. The assessment procedures
5. Treatment procedures and protocols
6. The staffing patterns
7. Quality assurance procedures
8. Program evaluation procedures

3.5 There shall be a formalized (if not standardized) assessment to be filed at minimum at the beginning and at the end of the treatment. The initial assessment will be aimed at delineating the functional deficits that the client has and at establishing treatment goals for each client and family. The final assessment will be utilized for determining change at the end of the treatment program. It is expected that ongoing, monitoring of progress be provided throughout the course of treatment.

3.6 After the initial assessment of the client 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. Focus on maximizing independent functioning and return to normalcy of the client in the environment and community outside of the program or facility
2. Be based on the review of referral information and evaluation of the client's specific needs
3. Preserve the dignity and personal safety of the client
4. Be reviewed at regular time intervals to assess progress, methods and goals
5. Be coordinated with other treatment provided to individual by community agencies
6. Be clearly outlined in the discharge summary
7. Provide for mechanisms of family involvement.
8. Provide for community reintegration services to be overseen by the program director and/or his/her assignees on a regular and frequent basis
9. The goals of the treatment plan should be specified in clear terms
10. There shall be an estimate made to the client and family or representative indicating the expected duration of the treatment
11. The design and implementation of treatment intervention should not encourage or support unrealistic expectations or excessive frustrations

3.7 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. Procedures and policies for medical emergencies.
2. Provision for exchange of pertinent medical information
3. Indications of rehabilitation problems
4. Medical contraindication
5. Review of medication
6. Providing by affiliation for referral abilities to any disciplines needed including appropriate specialists as may be required to provide optimal care

3.8 Appropriate policies and procedures for referring clients to community, state and other agencies should be established.

3.9 The facility should maintain a standard for collec-

tion 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.

3.10 Cases should be conferenced at a minimum of once per month. All treatment parties should be present or represented for the purpose of reviewing progress and updating the interdisciplinary treatment plan. Formal conference summaries should be included in the case record containing quantified data, progress, intended treatment and discharge status.

3.11 To the extent possible, families of clients shall be made aware of treatment progress and goals. Treatment efforts shall be directed at integrating changes into the client's family setting.

3.12 There shall be a system of documenting each client's contact.

3.13 A policy for discharge criteria should be established in which discharge is based on either successful achievement of the treatment program, failure to meet minimum goals within a specific period of time, or other reasonable criteria.

3.14 A formal discharge summary, including specific statements regarding outcome, and recommendations for further treatment/management, must be provided, within the timeframe specified by the facility.

3.15 Each case should be reviewed by the program director or his/her assignee to ensure consistent overview of the treatment progress and planning.

3.16 A case manager should be assigned who can facilitate program coordination, community interaction, family interaction, etc.

3.17 There shall be an appropriate level of qualified staff so as to ensure that professional personnel can adequately maintain the treatment planning and measurement of treatment effect.

3.18 The professional personnel should maintain one-to-one treatment contact with each client on a frequency sufficient to allow for professional oversight and input to the treatment process.

3.19 Disciplines represented should include Physical Therapy, Occupational Therapy, Speech Pathology,

Psychology, and Social Work at the very minimum and ideally include staff representation and other appropriate disciplines.

3.20 The staff should be designated with appropriate expertise and current training in brain injury and treatment to allow for specialization and concentration on the varied disabilities presented by this population.

3.21 Orientation: Policy shall be in place for brain injury service to provide orientation to each new staff member assigned to the brain injury out-patient service on the role of each discipline.

3.22 The program director should have a minimum of two years experience in brain injury rehabilitation management and specific training that will enable him/her to understand and respond to the unique needs of brain injured patients .

3.23 The facility should maintain appropriate licensure and accreditation status with state and national organizations.

3.24 Each facility's program must develop a system for assessing the effectiveness of their program.

3.25 Program evaluation and quality assurance should be maintained by documenting 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. Follow-up of client to determine to what degree the program has been successful and what program changes may be necessary to maximize success in future clients

3.26 The results of the program evaluation shall be incorporated into changes in the structure of the program so that ineffective or inefficient procedures can be discontinued.

3.27 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.

3.28 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.

3.29 There shall be a policy and procedures in place to resolve patients' concerns or grievances within an established timeframe.

3.30 The Brain Injury Outpatient Rehabilitation Center will report their cases and provide information to the Brain and Spinal Cord Injury Central Registry.

3.31 The Brain Injury Outpatient Rehabilitation Center will be an integral part of the Florida Department of Health Brain and Spinal Cord Injury Program.

3.32 The Rehabilitation facility is encouraged to associate and participate with local, state and national brain injury associations.

Brain Injury Outpatient Psychology Standards

Neuropsychology for brain injury is a sub-specialty of psychology. Its primary purpose is to maximize function in individuals with brain injury from a behavioral, psychological, and cognitive perspective. It accomplishes this task through appropriate assessment of behavioral, psychological, and cognitive factors which are related to functional outcomes; and utilizes the results of these assessments with an interdisciplinary team approach to develop an effective rehabilitation plan. In addition, it provides specific behavioral, psychological, and cognitive interventions with brain injured individuals, their families and significant others to maximize physical, psychological and cognitive function, independence, and quality of life.

3.33 Psychologists should participate in ongoing brain injury prevention programs where applicable.

3.34 Psychologists on the Brain Injury Service should be involved in program and policy development especially where it involves patients with a brain injury.

3.35 Psychologists on the Brain Injury Service should participate in program evaluation to assure quality.

4.0 Pediatric Inpatient Rehabilitation 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, and age and developmentally appropriate equipment, furniture and materials for children and adolescents.

Though the family is the essential source of support and an adjunct to treatment in adult rehabilitation, the goal is to help patients care for themselves. In pediatric rehabilitation, it is essential to teach the family how to care and promote independence for the child while bal-

ancing 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.

While the vocational rehabilitation for adults is work related, the pediatric rehabilitation focus is on the child in the educational setting. For the child, attending school is normalizing. For the parent, school provides respite from their caretaker role. For the school, providing an education for a child with a disability may involve structural modifications, additional staff, specialized training, and equipment. 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 Pediatric Inpatient and Outpatient Brain and Spinal Cord Injury Program Rehabilitation Standards have been developed with this goal in mind.

4.1 The Pediatric Rehabilitation Program shall be accredited by Commission on Accreditation of Rehabilitation Facilities and Joint Commission on the Accreditation of Hospital Organizations. Pediatric age group may include those children from 0 to 21 years old. Patient grouping within the unit shall respect each patient's developmental and social level. Patients 16 to 21 years old may be designated for either a Pediatric or an Adult Rehabilitation Center, depending upon both the nature of the case and the nature of the facility.

4.2 There should be a volume of admissions sufficient to support a comprehensive, categorically designated program of services. A minimum of 30 admissions to the pediatric unit per year, with non-traumatic brain and spinal cord injury diagnosis included in the total number, is recommended with the intent to maintain a level of expertise in the area of pediatric rehabilitation.

4.3 Each designated Pediatric Rehabilitation Program shall make available to the 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 of that acute care hospital.

4.4 The organization has written policies which establish criteria for admission and require specific patient information from referring sources (i.e., comprehensive medical history, associated illnesses and injuries, behavioral status, cognitive status, pre-morbid school performance, family and other support systems, pre-morbid social history). Admission criteria should be distributed to referral sources.

4.5 There should be specific and appropriate units designated for the rehabilitation of children with neuro-trauma 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
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. Electrical outlet covers, locks and safety catches on appropriate drawers and doors

4.6 There should be a designated team representative(s) who has pediatric experience and who has the responsibility to:

1. Facilitate referrals and admissions to the Rehabilitation Center, as well as transfers to and from acute facilities
2. Disseminate information to related agencies and institutions
3. Liaison with state agencies, school systems and insurance companies
4. Coordinate discharge planning with appropriate parties
5. Coordinate disaster relief efforts with county and state Emergency Management officials

4.7 The pediatric program shall have a documented system for program evaluation and annual program review. This includes evaluation of data collected on each child/adolescent at admission and discharge, to measure progress over time. It is encouraged that persons from outside the program participate in the annual review process.

4.8 Provisions should exist for ensuring a safe and secure environment, including the provision of close

supervision as needed, consistent with the unique behavioral, cognitive and medical limitations of this population.

4.9 There should be a designated person responsible for reporting data to the Brain and Spinal Cord Injury Central Registry.

4.10 There should be an established process of ongoing contact with third party payers and relevant public and community agencies including, but not limited to, the Department of Health, Department of Children and Families, the Social Security Administration and the school system.

4.11 All staff in pediatric brain injury and spinal cord injury programs shall have specific training and experience with the population served.

4.12 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

4.13 In addition to a pediatrician, medical consultation services need to be available. These should include, but are not limited to, the following specialty areas in pediatrics:

1. Physical medicine and rehabilitation
2. Neurosurgery
3. Orthopedic surgery
4. Neurology
5. Infectious disease
6. Ophthalmology
7. Otorhinolaryngology
8. Surgery
9. Plastic/reconstructive surgery
10. Urology
11. Psychiatry
12. Pulmonology
13. Gastroenterology
14. Cardiology

4.14 All pediatric centers shall provide for the appropriate educational needs of their hospitalized patients through liaisons with local school districts, and/or educational resources.

4.15 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. Respiratory therapy
2. Vocational services
3. Audiology
4. Dentistry
5. Orthotics/prosthetics
6. Dietetic/nutrition
7. Drivers education (when necessary)
8. Sex education (when necessary)
9. Rehabilitation engineering
10. Pharmacy
11. Therapeutic recreation or child life specialist
12. Clinical Social Worker

4.16 Diagnostic services should be available or readily accessible on a referral basis including:

1. Electro-diagnostic services, including EEG, EMG, and evoked potentials
2. Radiology services, including CT scan and MRI
3. Laboratory services

4.17 An initial formal interdisciplinary assessment should be performed on each child within the first two weeks of admission and a similar formal assessment should be performed periodically or at minimum one additional time before discharge. These assessments should address the following:

1. Medical status
2. Medical and neurological issues
3. Health and nutrition
4. Sensorimotor capacity, including gross and fine motor strength and control, sensation, balance, joint range of motion, mobility and function
5. Cognitive status
6. Perceptual skills
7. Communication skills
8. Affect and mood
9. Psychological status
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. Educational potential (when applicable)
16. Sexuality (when applicable)
17. Family
18. Legal competency status
19. Community reintegration, including appropriate discharge services
20. Environmental modification, including adaptive equipment needs
21. All other deemed relevant for the person

4.18 An integrated, interdisciplinary treatment plan should be developed and continually revised based on patient status which should include, but not be limited to, the following treatment interventions where clinically appropriate:

1. Medical management
2. Behavioral management program
3. Cognitive retraining program
4. Family counseling/therapy
5. Speech and language therapy
6. Psychological services
7. Physical therapy
8. Occupational therapy
9. Rehabilitation nursing
10. Therapeutic recreation
11. Functional daily living skills training
12. Community reintegration skills training
13. Social skills training
14. Sexual functioning education and training
15. Educational interventions
16. Clinical Social Work

4.19 Pediatric facilities shall make every effort to integrate caretakers, guardians and siblings of patients into the evaluation, treatment, and discharge planning process, and provide evidence and documentation of each stage. In addition, the patient, family and significant others should be provided with information regarding available options for follow-up care, community services and/or alternative programs.

4.20 The Pediatric Rehabilitation Program shall have the capability of transporting patients in wheelchairs. The emphasis of the transportation utilization should be for community re-entry, recreational, vocational and social activities.

4.21 The Pediatric Rehabilitation Program shall provide a multi-purpose room for social, educational and other group activities and meetings.

4.22 Access to a playroom/recreational area proximal to the rehabilitation center should be provided.

4.23 The facility must have a communal dining area.

4.24 The Pediatric Rehabilitation Center shall actively participate in the state of Florida Brain and Spinal Cord Injury Program.

4.25 A brain or spinal cord injury prevention program shall be ongoing. It should include at minimum the following components:

1. Ongoing community awareness programs that may include the local media to target specific prevention concerns.
2. Regularly scheduled brain or spinal cord injury interventions with specific curriculum implemented in local elementary, middle or high schools:
 - a. Epidemiology of injury on both local and national level
 - b. Consequences of injury (to include physical, cognitive, emotional, social and financial)
 - c. Prevention techniques
 - d. First responder considerations
 - e. Brain or spinal cord injured survivor to relate their personal experience with injury
3. A designated brain and spinal cord injury prevention coordinator
4. Demonstrated involvement or collaboration with other organizations involved in prevention activities.
5. Support legislation that will influence public policy decisions to prevent brain and spinal cord injuries
6. Familiarity with ongoing injury prevention programs and local epidemiology of injury
7. The ability to serve as an injury prevention resource for the community

4.26 All staff should show documentation of continuing education programs appropriate to clients served.

4.27 Facilities should encourage all staff to participate in community and professional organizations relating to brain and spinal cord injury.

4.28 Pediatric Outpatient Rehabilitation Standards

4.29 A Pediatric Outpatient Rehabilitation Program is a goal oriented, interdisciplinary, outpatient therapy program specifically designed to improve the physical, cognitive, communicative, behavioral, psychological and

social functioning of children surviving brain and spinal cord injuries. In addition, these centers address the negative social and behavioral consequences of the injury.

4.30 This program may be free standing or a component of another rehabilitation facility. The Rehabilitation Center's primary patient population must have sustained a brain or spinal cord injury and carry a case load of at least ten patients ongoing per year, or 50 outpatient contact visits per week.

4.31 Pediatric age group shall include those children from 0 to 21 years old. Patient grouping within the unit shall respect each patient's developmental and social level. Those patients 16 to 21 years old may be designated for either a Pediatric or Adult Outpatient Rehabilitation Center depending upon both the nature of the case and the nature of the facility.

4.32 Standards for admission to the Pediatric Outpatient Rehabilitation Program should include the following:

1. That children be classified as brain or spinal cord injured
2. That children be in need of therapeutic intervention for the improvement of physical, cognitive, communicative, behavioral, psychological, social or emotion functioning
3. There should be an indication that the child can benefit from rehabilitation efforts
4. The child should be manageable within the staffing limitations of the center
5. The child should have no major medical condition that precludes attendance or participation in the program
6. The center should make a formal request for pertinent medical and educational records

4.33 The Pediatric Outpatient Rehabilitation Program should offer, either by the program or through consultation arrangements, the following services by professionals having training and experience with children:

1. Physical restoration services including physical therapy
2. Speech/language pathology services
3. Cognitive remediation
4. Development of activities of daily independence living
5. Psychological adjustment
6. Development of appropriate social interaction skills
7. Behavioral management abilities or contingencies
8. Pre-vocational or vocational skills development

9. Education services appropriate to the child's level
10. Development of recreation and leisure activities
11. Use of community resources
12. Client screening and evaluation procedures
13. Liaison and coordination with community agencies and school system in the child's local or home community
14. Documented training and supervision to all staff on a continuing basis
15. Referral to physician for review of medical needs
16. Referral to rehabilitation nursing for evaluation and follow up as necessary

4.34 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. Treatment procedures and protocols
6. The staffing patterns
7. Quality assurance procedures
8. Program evaluation procedures

4.35 There shall be a formalized (if not standardized) assessment to be filed at the beginning and at the end of the treatment. The initial assessment will be aimed at delineating the functional deficits that the child has and at establishing treatment goals for each child. The final assessment will be utilized for determining change at the end of the treatment program. It is expected that ongoing monitoring of progress be provided throughout the course of treatment.

4.36 After the initial assessment of the child, there shall be a written plan developed for treatment including treatment objectives, guidelines for discharge or advancement to another program component. The treatment plan should:

1. Focus on maximizing independent functioning and return to normalcy of the child in the environment and community outside of the program or facility
2. Be based on the review of referral information and evaluation of the child's specific needs
3. Preserve the dignity/personal safety of the child
4. Be reviewed at regular time intervals to assess progress, methods and goals
5. Be coordinated with other treatment provided to the individual by others in the community

6. Be clearly outlined in the discharge summary
7. Provide mechanisms for the family improvement
8. Provide for community reintegration services, specially regarding the child's return to school which shall be overseen by the program director or assignees on a regular basis
9. Include goals that are specified in clear terms
10. Include an estimate made to the child and family indicating expected duration of treatment and anticipated time frames for accomplishment of specific goals
11. Not encourage or support unrealistic expectations or excessive frustrations

4.37 The program should establish policies and procedures which identify and ensure conformity with the functions and responsibilities of the prescribing or referring physician, including:

1. Procedures and policies for medical emergencies
2. Provisions for exchange of pertinent medical information
3. Indications of rehabilitation problems
4. Medical contraindication
5. Monitoring of medication
6. Availability of medical consultation services. These should include, but are not limited to, the following specialty areas in pediatrics:
 - a. Physical medicine and rehabilitation
 - b. Neurosurgery
 - c. Orthopedic surgery
 - d. Neurology
 - e. Infectious disease
 - f. Ophthalmology
 - g. Otorhinolaryngology
 - h. Surgery
 - i. Plastic/reconstructive surgery
 - j. Urology
 - k. Psychiatry
 - l. Pulmonology
 - m. Gastroenterology
 - n. Cardiology

4.38 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. Respiratory therapy
2. Vocational services
3. Audiology
4. Dentistry

5. Orthotics/prosthetics
6. Dietetic/nutrition
7. Drivers education (when necessary)
8. Sex education (when necessary)
9. Rehabilitation engineering
10. Pharmacy
11. Therapeutic recreation or child life specialist
12. Liaison with the following programs and agencies:
 - a. Social Security Administration
 - b. Vocational Rehabilitation
 - c. Children’s Medical Services
 - d. Children’s Mental Health Program
 - e. Developmental Disabilities Program
 - f. Local school system

4.39 Diagnostic services should be available or readily accessible on a referral basis, including:

1. Electro-diagnostic services, including EEG, EMG, and evoked potentials
2. Radiology services, including CT SCAN and MRI
3. Laboratory services

4.40 Appropriate policies and procedures for referring children to community, state and other agencies should be established.

4.41 Policies and procedures for follow-up post discharge should be established.

4.42 The facility should maintain a standard of collecting quantifiable data substantiating current treatment status and progress review. All disciplines should provide continuous measurable data to be included in all verbal and written progress reports.

4.43 Test-retest guidelines should be established and routinely scheduled and administered. This schedule should be maintained for both formal and informal testing in all disciplines.

4.44 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. Formal conference summaries should be included in the case record containing objective data, progress noted, intended treatment and discharge status.

4.45 Families of client shall be involved in the assessment, treatment and continuing care of the child. This

shall include their being made aware of treatment progress and goals and the center aiding them in coping with their child’s injury. Treatment efforts shall be directed at integrating changes into the child’s family setting.

4.46 There shall be a system of documenting each client’s contact.

4.47 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.

4.48 A formal discharge summary, including specific statements regarding outcome, and when appropriate, recommendations for further treatment/management, must be provided.

4.49 Each case should be reviewed by the program director or assignee to ensure consistent overview of the treatment progress and planning.

4.50 Each child shall be assigned a case manager with pediatric experience responsible for facilitating program coordination, community interaction, school liaison, family interaction, etc.

4.51 The program should be staffed by an appropriate level of licensed, accredited staff and non-licensed, accredited staff to ensure that treatment planning and measurement of treatment effect are adequately maintained by professional personnel.

4.52 Professional personnel should maintain one-to-one treatment contact with each child on a frequency sufficient for professional oversight and input to the treatment process.

4.53 Disciplines represented should include physical therapy, occupational therapy, speech pathology, academic therapy, psychology, rehabilitation nursing and social work as appropriate. It would ideally include staff representation or consultation agreement with Division of Vocational Rehabilitation, the local school system personnel, and other appropriate disciplines.

4.54 The staff should be designated primarily to rehabilitation treatment to allow for specialization and concentration on the varied disabilities presented by this population.

4.55 The staff should have specific training that enables

them to understand and respond to the unique needs of children with brain or spinal cord injury and their family. All individuals responsible for the assessment, treatment or care of children should have training and expertise such that they are competent in the following:

1. Ability to obtain and interpret information on terms of the child's needs
2. A knowledge of growth and development
3. An understanding of the range of treatment needed by these patients
4. Showing documentation of continuing education programs appropriate to clients served

4.56 Facilities should encourage all staff to participate in community and professional organizations relating to brain and spinal cord injury.

4.57 The program director should have a minimum of two years experience in brain or spinal cord injury rehabilitation management and specific training which will enable understanding and response to the unique needs of this population.

4.58 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

4.59 The facility should maintain appropriate licensure and accreditation status with state and national organizations.

4.60 The program must develop a system of program evaluation to determine overall effectiveness.

4.61 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
6. Post-treatment vocational status
7. Pre-treatment academic status

8. Post-treatment academic status
9. 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 clients

4.62 There shall be a system for a periodic review of the program on an annual basis. It is encouraged that persons from outside the program participate in the process.

4.63 The results of the program evaluation shall be incorporated into changes in the structure of the program to increase efficiency and effectiveness.

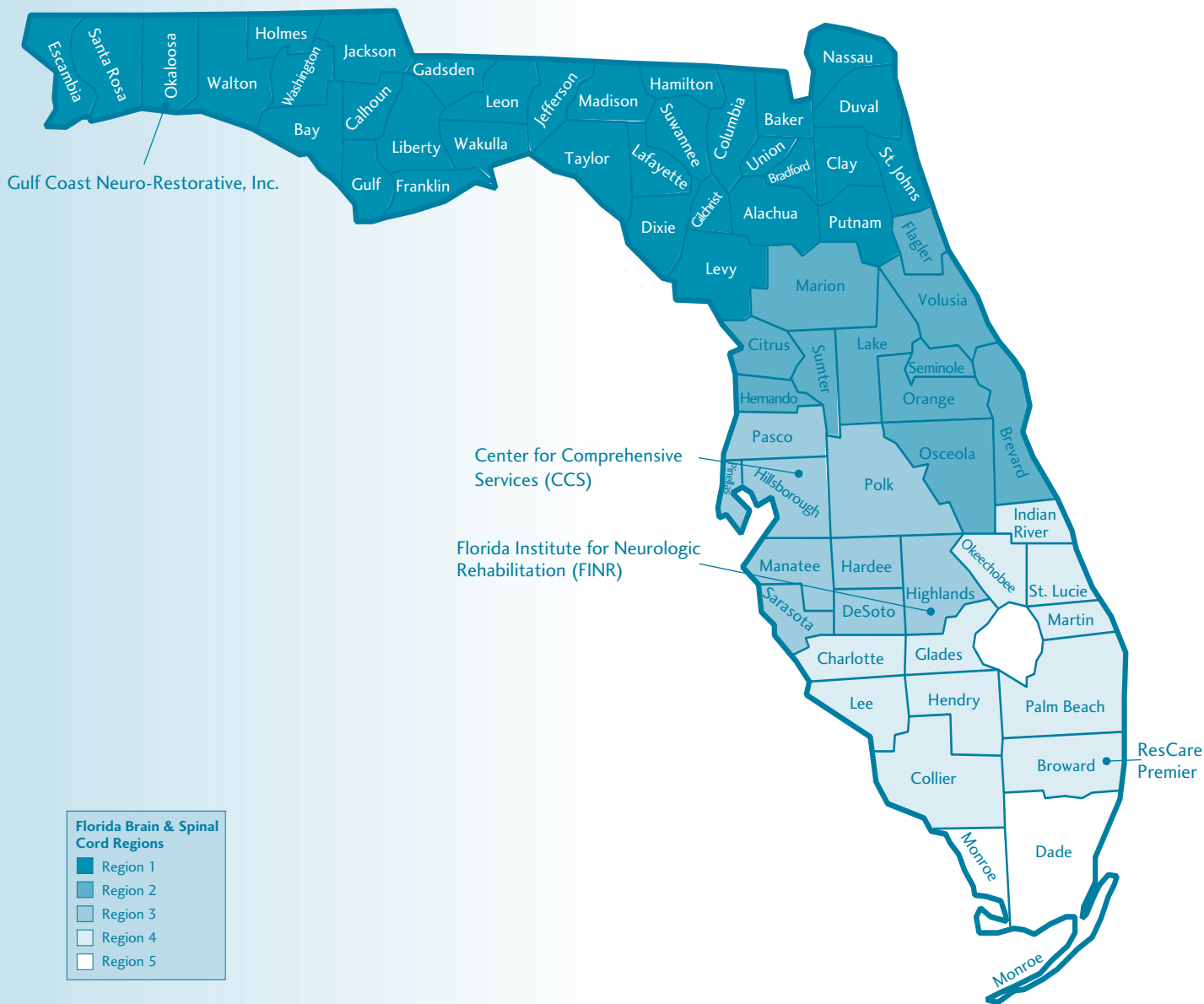
4.64 Advertising of the program shall be limited to program descriptions provided in such a way that the consumer or purchaser of services is aware of both the scope and the limitations of the treatment program.

4.65 When misconceptions about treatment do occur, the provider of services will make a reasonable attempt to clarify the misconception.

4.66 The Pediatric Outpatient Rehabilitation Program will report their cases and provide information to the Brain and Spinal Cord Injury Central Registry.

4.67 The Pediatric Outpatient Rehabilitation Program will be an integral part of the Florida Brain and Spinal Cord Injury Program.

FLORIDA BRAIN & SPINAL CORD INJURY PROGRAM
**current designated brain injury
 transitional living facilities**



5.0 Transitional living facility Standards

Transitional Living Facility means a site where specialized health care services are provided including, but not limited to, rehabilitation services, community re-entry training, aids for independent living and counseling to individuals with brain or spinal cord injury.

Intent: Transitional Living Facilities provide individuals with brain or spinal cord injury a temporary, structured residential program. The intent of these programs is to focus on preparing participants to return to community living. The program of service is provided in a residential setting, is time-limited and is goal oriented to improve the person’s physical, cognitive, communicative, behavioral, psychological, and social functioning under the necessary support and supervision.

Goal: The goal of a transitional living program for persons who have a brain or spinal cord injury is to assist each person to achieve a higher level of independent functioning and to enable that person to re-enter the community.

Objectives

A. To establish and maintain transitional living Facilities in an appropriate number of locations to address the needs of individuals who sustain brain or spinal cord injury.

B. To ensure that individuals are provided appropriate services that will assist them in reaching their maximum level of functioning in the community.

C. To assist clients in obtaining skills necessary to function independently in the community.

D. To provide services in the least restrictive environment in a safe and supportive setting. These services will be provided in a cost effective and timely manner.

Transitional Living Facility Standards

5.1 The facility must be licensed by the Agency for Health Care Administration, state of Florida, as required in Section 400.805, Florida Statutes.

5.2 The facility must be accredited by the Commission of Accreditation of Rehabilitation Facilities in Home and Community-Based Rehabilitation Programs for persons with spinal cord injuries and Community Integrated Programs for persons with brain injuries.

[it's the last thing on your mind
until it's the only thing on your mind.]



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