

9. STANDARDS AND GUIDELINES IN AMPUTEE AND PROSTHETIC REHABILITATION

- 9.1 The proposed Standards and Guidelines are based on national consensus. The key recommendations from the background information in chapters 4-8 were initially extracted as Standards and Guidelines. The process of achieving consensus is described in detail in paragraph 1.14.
- 9.2 Guidelines are lists of recommendations that guide clinicians in the management of individual patients with a particular condition or problem while Standards are recommendations which apply to services or populations, against which audit may be conducted¹. The statements in Section 4 and 5 are, for the most part, more properly to be considered as Guidelines as they follow individual patient pathways whereas all other statements relate to service delivery and should therefore be regarded as Standards.
- 9.3 The standards are in a format identical to the BSRM Standards for Specialist Inpatient Rehabilitation Services² and for Community Rehabilitation Services³. The Standards marked with an asterisk* are quoted directly from the previously published BSRM Standards.
- 9.4 The Standards have been prioritised, into three categories, defined in The King's Fund Organizational Audit Tool⁴:

Kings Fund Organisational Audit Categories for Standards:

Category	Definition
A	Essential Practice If these are not in place then: Legal and/or professional requirements will not be met A risk to patients, staff or visitors will be created The patient's rights, in terms of The Patient's Charter, will be compromised
B	Good Practice Standard good practice expected to be in place in any hospital/Trust across the UK
C	Desirable Practice Good practice which is not yet standard across the UK

- 9.5 To conform to the above definitions, the term 'must' has been used for all standards in category 'A' and 'should' has been used for standards in categories 'B' and 'C'.

9.6 Standards for Amputee and Prosthetic Rehabilitation:

1.	SERVICE PROVISION	A=Essential Practice B=Good Practice C=Desirable Practice
1.1	The Prosthetic and Amputee Rehabilitation Service must be regarded as a ‘Specialist Service’, as per the national definition of Specialist Services.	(A)
1.2	Every Prosthetic and Amputee Rehabilitation Centre (PARC) must have an agreed and written Operational Policy	(A)
1.3	Each PARC must have an appropriately trained Consultant in Rehabilitation Medicine who will be in charge of the overall care of the patient.	(A)
1.4*	Service Users within any district should have access to all appropriate Rehabilitation services which aim to maximise physical, psychological and social well-being, including: <ul style="list-style-type: none"> • Specialist in-patient Rehabilitation services • Out-patient and day Rehabilitation supported by adequate transport systems to ensure reliable attendance • Home-based/domiciliary Rehabilitation services which should be available for those unable to travel to a Rehabilitation Centre, or for whom Rehabilitation is more appropriately conducted in the context of their normal home environment 	(B)
1.5*	Co-ordinated service planning should ensure that suitable services are available within a reasonable travelling distance. (In rural areas, this may involve the establishment of satellite services or peripatetic teams to reach isolated locations)	(B)
1.6	The Senior Manager and Consultant responsible for the Rehabilitation Service should be involved in the making of Service Agreements with the Commissioners of Health Care for the catchment population.	(A)
1.7	These Service Agreements must take account of the minority of patients with rare, multiple, or particularly complex needs, who may need to cross the standard geographical boundaries in order to obtain optimal care.	(A)
1.8*	Where gaps exist in local service provision, defined systems for referral and funding should be in place to ensure that service users/patients can gain timely access to services which are not available in their locality.	(B)
1.9	The Senior Manager and the Consultant responsible for the Prosthetic Rehabilitation Service must be involved in the placing and subsequent monitoring of all Contracts for the manufacture, provision, fit, delivery, repair and maintenance of Prostheses.	(A)
1.10	These Contracts (whether private or in-house) must be selected on the basis of competitive tendering, based on quality as well as price. Subject to suitable safeguards and annual review, such contracts should be for at least five years, with the option to roll on for a further two years or more, as shorter contract periods are extremely disruptive to patient care.	(A)
1.11	The Consultant and the Manager should be the official representatives of the PARC in matters relating to the Trust.	(B)
1.12	At all PARCs patients must have adequate access to relevant information in appropriate formats and in a choice of languages.	(A)
1.13	The PARC must have on site, a Prosthetic Workshop equipped to deal with the day to day adjustment or repair and assembly of the majority of prostheses.	(A)
1.14	Centres providing prosthetic services for upper limb loss and congenital limb deficiency must fulfil defined criteria for these services.	(A)
1.15	The number of Consultants at each Centre will depend on the case mix and other commitments, but each Consultant should undertake a minimum of three notional half days (NHD’s), including flexible sessions, in Amputee Rehabilitation.	(B)

SERVICE PROVISION (continued)

A=Essential Practice
B=Good Practice
C=Desirable Practice

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| 1.16 | Each patient must have a named Consultant in Rehabilitation Medicine and a named Prosthetist. | (A) |
| 1.17 | Each PARC must have a structure in place to fulfil the requirements of Clinical Governance. | (A) |
| 1.18 | Each PARC must have an established complaints procedure. | (A) |
| 1.19 | The PARC must provide equity of access for all, irrespective of age or disability(ies). | (A) |
| 1.20 | The PARC should ensure provision of appropriate transport for patients as clinical needs dictate. | (B) |
| 1.21 | Every PARC should have adequate facilities for the collection of, and should collect, statistical data relating to Amputee Rehabilitation and prosthetics for the National Amputee Statistical Database (NASDAB). | (B) |
| 1.22 | Patients and Carers should be involved in the planning and review of Rehabilitation services in their area. | (B) |
| 1.23 | Each PARC should have and proactively support a Users' Consultative Committee, made up of a representative sample of users /patients/carers of the Centre in collaboration with appropriate staff. | (B) |

2. REHABILITATION TEAM

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| 2.1 | Rehabilitation must be carried out by a co-ordinated inter- or multi-disciplinary team(s). | (A) |
| | At the District General Hospital | |
| 2.2 | Each District General Hospital should have at least one Consultant Surgeon with special responsibility for amputation surgery (usually a Vascular Surgeon). | (B) |
| 2.3 | The District General Hospital should have a designated and appropriately trained Therapist or other Allied Health Professional to co-ordinate Amputee treatment. | (B) |
| 2.4 | The District General Hospital must have an Occupational Therapy service familiar with needs of new amputees or must have access to same. | (A) |
| 2.5 | The District General Hospital must have a physiotherapist experienced in amputee Rehabilitation to supervise pre-operative and post operative physiotherapy management, which includes assessment and treatment, using appropriate early walking aids or have access to same. | (A) |
| 2.6 | The District General Hospital should have a Social Worker/Care Manager with either suitable experience of the needs of amputees or access to appropriate information. | (C) |
| 2.7 | The District General Hospital must make provision for the Rehabilitation of those amputees not suitable for Prosthetic Rehabilitation after liaison with the PARC. | (A) |
| | At Prosthetic & Amputee Rehabilitation Centre | |
| 2.8 | The Multi-Disciplinary Team at each PARC must include a Rehabilitation Physician, Prosthetists, a Specialist Physiotherapist, and a Specialist Occupational Therapist. | (A) |
| 2.9 | When appropriate, patients at all PARCs should have access to an Orthotist, Counsellor, Social Worker, Clinical Psychologist, Rehabilitation Engineer, Podiatrist, Clinical Nurse Specialist and Employment Advisor. | (B) |
| 2.10 | The composition of the Multi Disciplinary Team at each Centre must be appropriate to the level of service provided (see paragraphs 4.5, 4.15 and 4.19). | (A) |
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3. REFERRAL	A=Essential Practice B=Good Practice C=Desirable Practice
3.1* Specialist Rehabilitation services should have: <ul style="list-style-type: none"> • A defined inclusion criteria and • A written procedure for referral and for assessment 	(B)
3.2* Referral will be accepted from an appropriate agency (with the agreement of the physician or surgeon) in accordance with the written referral procedure.	(B)
3.3* Where relevant, the funding/contract should be agreed prior to assessment to avoid disappointment.	(B)
3.4 Receipt of referral should be acknowledged promptly with an appointment or relevant information if there is a delay in the appointment.	(B)
4. START OF REHABILITATION	
Pre-amputation phase	
4.1 A pre amputation consultation with an appropriate PARC team member, should be arranged where amputation is a treatment option (as opposed to treatment necessity).	(B)
4.2 During pre-amputation consultation, for upper limb amputees, particular emphasis should be placed on the likely function with and without a prosthesis.	(B)
4.3 A meeting with an appropriate established amputee should be considered before every case of elective amputation.	(C)
4.4 Unless clinically contra-indicated a Rehabilitation programme should be started pre-operatively.	(B)
The Amputation	
4.5 The amputation must be performed by a suitably experienced surgeon using currently recognised operative techniques with due consideration of future Rehabilitation potential including prosthetic use, except in cases of extreme urgency.	(A)
4.6 All upper limb amputations must be carried out by an appropriately experienced upper limb surgeon using currently recognised upper limb amputation techniques except in cases of extreme urgency.	(A)
4.7 The surgical team must ensure that the patient has adequate peri-operative pain control, including use of pre-operative techniques like epidural analgesia if indicated.	(A)
4.8 Surgical team must liaise with the PARC when clinically indicated	(A)
5. REHABILITATION ASSESSMENT AND PROGRAMME PLANNING PHASE	
Assessment	
5.1 All amputees, must be offered referral to the PARC.	(A)
5.2* Relevant clinical information, together with any special needs, is reviewed by the PARC staff and any necessary action or provision is implemented prior to the arrival of the individual.	(A)
5.3 At the PARC the patient should be assessed by the multidisciplinary team, as appropriate.	(A)
5.4 Following assessment, realistic Rehabilitation goals should be set with the agreement of the patient and documented, including reasons for any failure to reach agreement.	(B)
5.5 The patient must be informed about the outcome of the assessment.	(A)
5.6 If Prosthetic Rehabilitation is planned, the prosthesis should be prescribed after consultation with relevant members of the multi-disciplinary team.	(B)

REHABILITATION ASSESSMENT AND PROGRAMME PLANNING PHASE <i>(continued)</i>		A=Essential Practice B=Good Practice C=Desirable Practice
5.7*	Following assessment a letter/written summary should be supplied to the referrer, summarising the case and the individuals Rehabilitation needs, with recommendations for management and the intervention plan. This should be copied to the GP and other relevant agencies, including the individual (patient) if appropriate.	(A)
Programme Planning Phase		
5.8	For complex cases, an inpatient facility, offering continued Prosthetic Rehabilitation should be available.	(C)
5.9	All patients must be given information about Rehabilitation and lifestyle options as an amputee.	(A)
5.10	If a prosthesis is not being prescribed, the patient, relatives and carers and referrers should be given reasons for the decision and alternative Rehabilitation plans must be documented and implemented.	(A)
5.11	Experienced clinical counselling and psychological support should be available for all upper limb amputees.	(B)
5.12	All new patients attending the PARC should be made aware of the availability of counselling.	(B)
5.13	All PARCs should have a written and agreed policy for the provision of <ul style="list-style-type: none"> • Cosmeses • Leisure Limbs and • Water Activity Limbs 	(B)

6. THE REHABILITATION PROGRAMME

6.1	Prosthetists must follow the manufacturers' instructions and guidelines on risk management and any deviations from standard practice must be fully documented .	(A)
6.2	The completed prosthesis should be delivered satisfactorily within the contractually stated time.	(A)
6.3	The patients should have direct access to team members as appropriate and in accordance with local guidelines	(B)
6.4	The service provided must be responsive to any individual patient's change in lifestyle, occupation or general health.	(A)
6.5	Outcome should be recorded during the Rehabilitation phase, preferably using validated outcome measures.	(B)
6.6	Adequate and appropriate attention must be given to the appearance and the cosmetic finish of the prosthesis.	(B)
6.7	Facilities for design and supply of custom made/one off appliances required for amputees especially for work related activities, should be available.	(B)
6.8	All amputees should have access to Vocational Rehabilitation (including advice on driving)	(C)
6.9	The appropriate follow up arrangements must be documented and appropriately explained to the patient.	(A)
Congenital Limb Deficiency		
6.10	If a limb deficiency is detected during pregnancy, an antenatal referral to a Limb Deficiency Clinic should be offered.	(B)
6.11	The Paediatrician should refer to the Consultant in Rehabilitation Medicine specialising in Congenital Limb Deficiency at the tertiary PARC within one month of birth.	(B)

THE REHABILITATION PROGRAMME *(continued)*

A=Essential Practice
B=Good Practice
C=Desirable Practice

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| 6.12 | Where appropriate (for example where there are major joint abnormalities) the Paediatrician/Rehabilitation Consultant should, in consultation with parents/guardians, refer the child to a specialist orthopaedic surgeon. | (B) |
| 6.13 | The child and parents/guardians should be seen in a Specialist Limb Deficiency Clinic within 3 months of birth. | (B) |
| 6.14 | The parents/guardians must be given general and detailed expert advice on all relevant treatment options (including the advisability or otherwise of prosthetic and surgical management). | (A) |
| 6.15 | The multi-disciplinary team must provide ongoing care for the child and parents/guardians with appropriate and documented follow-up plan. | (A) |
| 6.16 | At the PARC, designated prosthetists with the appropriate specialist experience should look after all patients with Congenital Limb deficiency. | (A) |
| 6.17 | A therapist specialising/experienced in management of limb deficiency must be available to all children with Congenital Limb Deficiency. | (A) |
| 6.18 | Expert orthotic advice and treatment should be readily available. | (B) |
| 6.19 | Ongoing advice and help must be offered as the children become adolescents and adults | (A) |

7. DISCHARGE

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| 7.1 | If a patient is being transferred or discharged from the PARC, a report with an adequate clinical summary must be forwarded as appropriate. When the patient abandons limb use, reasons should be documented and GP informed. | (A) |
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8. FOLLOW-UP

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| 8.1* | All Rehabilitation facilities must have a written policy and procedure on follow-up. | (A) |
| 8.2 | For established amputees, the follow-up procedure should allow patients to have direct access to team members as appropriate and in accordance with local guidelines. | (B) |
| 8.3 | During the maintenance phase of established amputees, the service must be responsive to the changing needs of the patient. | (A) |
| 8.4 | Feedback to the GP and any other relevant authority should be provided on follow-up, when clinically indicated. | (B) |

9. STAFF DEVELOPMENT

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| 9.1* | Systems in place in the NHS Trust for quality assurance and clinical governance must apply. There should be a system of regular appraisal for all staff. | (A) |
| 9.2* | All professional staff should be kept up-to-date, and there should be a written policy on training. | (A) |
| 9.3* | Staff should have local access to up-to-date Rehabilitation textbooks and the major Rehabilitation journals relevant to their service. | (B) |
| 9.4* | Regular training must be available both within and between disciplines, and time must be allocated for training on a regular basis. | (A) |
| 9.5* | Since in-house training is unlikely to be sufficient to meet all training needs, adequate funding must be available to allow staff to meet their training needs at external meetings, at least some of which should be multi-professional. | (A) |
| 9.6* | Staff should be actively encouraged to attend national conferences, which will afford the opportunity to network with other colleagues both within and outside their own discipline. | (A) |
| 9.7* | All services must undertake audit as a routine part of clinical practice. | (A) |

STAFF DEVELOPMENT *(continued)*

A=Essential Practice
B=Good Practice
C=Desirable Practice

- 9.8* Audit should be undertaken as a multi-disciplinary activity. **(B)**
- 9.9* Audit sessions should be documented, and where change in practice is recommended, a named person should be designated to ensure implementation of those recommendations. **(B)**
- 9.10* Every opportunity should be sought for multi-disciplinary and inter-agency education and training, including the involvement of patients in management of disability and raising disability awareness. **(C)**

10. LIAISON WITH OTHER HEALTH CARE SERVICES & AGENCIES

- 10.1* There should be access to an appropriate range of specialist health care services in acute, mental health and community sectors beyond those provided directly by the Rehabilitation and multi-disciplinary team. These may include: **(B)**
- Diabetic services
 - Plastic surgery
 - Continence and tissue viability services
 - Wheelchairs and special seating
 - Occupational health etc
- 10.2* Rehabilitation services should have clearly identified policies or pathways for: **(C)**
- Working with general practitioners and primary care teams (generic services)
 - Support and specialist Rehabilitation for children and adolescents with disabilities approaching adult life
 - Transfer to care of the elderly Rehabilitation services for adults approaching later life
 - Representing individuals' interest in community settings, eg decision, making for those with special care needs or communication deficits whose competence to participate in decisions may require representation from a third party
- 10.3* There should be identified pathways to access and/or work with: **(C)**
- Social Services
 - Housing
 - Care agencies (including training for care staff for patients with complex needs)
 - Private sector agencies eg nursing homes
 - Education and further education including special needs and out-of area provision
 - Disability employment advisory services and facilities for preparation for work
 - Financial advice (Benefits Agency, Citizens Advise Bureau, Public Trust Office)
 - Legal advice (for patients and their families and carers)
 - Advocacy services – representing the individual's interest for those whose competence to participate in decisions about their care and their future is restricted
 - Charities, self help groups and voluntary agencies
 - Driving ability assessment centre(s)