

STANDARDS OF PRACTICE:
ARE THEY RELEVANT?

Mary Ann Loeffler

Metropolitan State College of Denver

Susan Henley

Colorado Mental Health Institute at Fort Logan

Standards of practice continue to be of concern to those in the therapeutic recreation (TR) profession. Concerns are multi-faceted: lack of awareness by practitioners and students of current internal and external standards of practice, understanding the purpose of the standards, relating their relevancy to community and clinical settings, the value of the standards to those outside of therapeutic recreation, and the relationship of standards to the future viability of the profession. All of these issues face therapeutic recreation practitioners today as they struggle with the dynamic and dramatic changes in health care systems and the concomitant changes in society as a whole. The question is, will standards of practice continue to play a significant role in the future of the therapeutic recreation profession as it continues its mission to assist special needs clients in their recovery and integration in society?

The authors intend to address the preceding issues by identifying the standards of practice guiding therapeutic recreation programs today, describing how these standards are perceived and utilized now, and predicting their value in the future. The first portion of this chapter discusses what a standard is and the two

types of standards that regulate and guide therapeutic recreation services. The second section explains therapeutic recreation's internal standards of practice. The third section critically explores the major external standards and compares them with our national therapeutic recreation standards. The fourth section focuses on the results of a survey conducted by the authors on the relevancy of therapeutic recreation standards of practice to today's world. In the final section recommendations are made to guide future therapeutic recreation practices.

WHAT IS A STANDARD OF PRACTICE?

Webster defines a standard as "something set or established by an authority, custom, or general consent as a model or example" (Webster, 1986). A standard is established by consensus or expert authority. It represents the ideal, values are involved. Therefore, a standard is by definition a statement or example of value. Standards of practice define a set of values about the practice they represent, and provide a means to evaluate the practice. A standard is then the desired level of performance against which actual performance is compared. According to Smith and Land (1993:99), "standards are developed for at least two major reasons: first, to guarantee a minimum level of service; and second, to assure the safety of the consumer." They serve both the public and the profession by delineating the guidelines for quality programs. For the therapeutic recreation profession, standards establish a minimum for measurement of competence of individuals practicing in therapeutic recreation.

WHAT TYPES OF STANDARDS EXIST?

There are two types of standards; external standards and internal standards. External standards are set by a regulatory or credentialing agency/institution. The second type are internal standards which are set by those delivering services. Any or all standards may be voluntary or mandated. Standards, whether internally or externally imposed, provide therapeutic recreation personnel with a structure to define, document, monitor and

improve their work. They also increase credibility of therapeutic recreation within an organization by focusing on key elements in TR practices in order to assist the TR professional in achieving consistent service outcomes. Standards promote recognition of common expectations, so TR professionals are seen as having practices and responsibilities similar to other peer professionals. Both internal and external standards are necessary to improve and assure the quality of TR services.

WHAT ARE INTERNAL STANDARDS ?

Internal standards in the field of therapeutic recreation guide the delivery of service to individuals with disabilities; they include standards of practice from the following organizations:

- American Therapeutic Recreation Association (ATRA), and/or
- National Therapeutic Recreation Society (NTRS).

The first standards in the profession were developed by the National Therapeutic Recreation Society in 1980. The document "Standards of Practice for Therapeutic Recreation Service" was developed to be utilized with the administrative guidelines for clinical settings. The companion document was the "Guidelines for Administration of Recreation Service in Clinical and Residential Facilities". For non-clinical or community settings the companion document was "Guidelines for Community-Based Recreation Programs for Special Populations". Revised standards published in 1994 by NTRS entitled "Standards of Practice for Therapeutic Recreation Services" are designed to serve as the basic framework for all therapeutic recreation services regardless of setting. These standards are to be used in conjunction with the "Guidelines for the Administration of Therapeutic Recreation Services" and the "Code of Ethics and Interpretive Guidelines". The NTRS standards address overall goals of each aspect of TR service, then specify criteria for development, implementation and content of each service area. Then in 1991, "The Standards for the Practice of Therapeutic Recreation" were developed by the American Therapeutic Recreation Association. This document addresses service provision by therapeutic recreation professionals in a variety of clinical settings.

The standards have two distinct areas of concern, the direct practice in TR and the management of the practice. The direct practice standards address the critical elements of service delivery for the successful treatment and the rehabilitation/habilitation of the patient/client. The management standards were developed to assist the TR professional and department to monitor their practice. These standards were written in a format compatible with a major external regulatory agency. They are comprehensive guidelines for TR services. The format presents each standard/function, followed by criteria identifying structure, process and outcome measurements. The structure criteria reflect measurement of the parameters of practice (e.g., environment, resources, policies, procedures...). The process criteria focus on the provision of therapeutic recreation services (e.g., intervention strategies, intra-agency collaboration...). Outcome criteria reflect a desired goal for the patient's/client's condition (e.g., improved functional level...) or the treatment service/delivery. However, TR standards have not been designed or included that specifically represent the variety of patient populations receiving TR services.

WHAT ARE EXTERNAL STANDARDS?

These standards are set by groups outside of therapeutic recreation to help monitor and improve services in a particular area (e.g., CARF for several types of rehabilitation agencies). Therapeutic recreation services would be only one part of monitoring for quality or safety. Examples of groups that set external standards which directly or indirectly affect TR include:

- The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
- The Commission on the Accreditation of Rehabilitation Facilities (CARF)
- The Health Care Finance Administration (HCFA), both Medicaid and Medicare
- Social Security Administration reviewing patients accounts, rate setting, reimbursement procedures.

- State Departments for workplace practices that protect the safety and health of both employee and client or to implement Public Laws and Policies
- City Departments for Fire, Personnel or Safety

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) is the largest and most influential private organization involved in voluntary accreditation in health care agencies. JCAHO strives to "enhance the quality of care and services provided in organized health care settings". (JCAHO, 1994: 4) These standards have expanded considerably since the 1960s when JCAHO accreditation became "The preferred route" by which hospitals demonstrated eligibility for Medicare and Medicaid reimbursement. More than 5,200 hospitals or approximately 80% of the nation's acute care general hospitals voluntarily participate in JCAHO activities.

Commissioners in JCAHO continuously develop and refine their standards and surveys. They evaluate health care organizations every one to three years to measure the agency's compliance with JCAHO standards. The surveyors grant or deny accreditation depending on the agency's compliance with its standards as well as recommend or require improvements by the agency to increase the quality of patient care. The commission publishes five accreditation manuals. The new *Comprehensive Accreditation Manual of Hospitals* (CAMH, 1995) and *Mental Health Manual* (MHM, 1995) which contain mental health, chemical dependency, mental retardation/developmental disability standards are a result of a nine-year process by JCAHO to revise standards to reflect important patient and organizational functions instead of the previous focus on hospital departments or discipline standards. This is a significant change in emphasis by JCAHO to performance-based standards now impacting functions that directly or indirectly affect patient outcomes and improve excellence in care: "Doing the right things and doing them well" (JCAHO, 1995:1). Three other accreditation manuals in process of revision are: the Accreditation Manual for Home Care (AMHC, 1995), Accreditation Manual for Long-Term Care (AM LTC, 1996), and Accreditation Manual for Ambulatory Healthcare (AHCSM, 1996). At the completion of the revision process by JCAHO in September, 1996, all five of these JCAHO manuals will reflect the following core chapters (as well as a

chapter on health promotion and disease prevention that is in the process of being developed):

Section 1 - Patient Focused Functions:

- Patient Rights and Organizational Ethics (RD)
- Assessment of Patients (PE)
- Care of Patients (TX)
- Education (PF)
- Continuum of Care (CC)

Section 2 - Organizational Functions

- Improving Organizational Performance (PI)
- Leadership (LD)
- Management of the Environment of Care (EC)
- Management of Human Resources (HR)
- Management of Information (IM)
- Surveillance, Prevention and Control of Infection (IC)

Section 3 - Structures with Functions:

- Governance (GO)
- Management (MA)
- Medical Staff (MS)
- Nursing (NR)

The Comprehensive Accreditation for Rehabilitation Facilities (CARF) expects at this time, all agencies accredited by their standards to meet five major principles: Policy on Input from Patients Served, Policy on Accessibility, Policy on Treatment Outcomes, Policy on Safety, and Policy on Legal Requirements. Organizations may also seek accreditation in Comprehensive Inpatient Categories One, Two, and Three as well as Spinal Cord Injury Programs, Brain Injury Programs, or Outpatient Medical Rehabilitation Programs. Currently, officials at CARF are revising its standards which were available as a 1995 draft to these authors. An example of a CARF (draft, 1995) standard with an accompanying interpretive guideline is:

Individual Plan

6. Based on referral and assessment information about the person's strengths, abilities, needs, and preferences, a comprehensive, coordinated individual plan should be developed and regularly assessed for each person served.

(Interpretive Guideline) 6c. ... Providing training in daily living skills to assist the person to use home equipment that will be available or to use the social, recreational, and spiritual services of the community to enrich the person's life. (CARF draft 1995:45).

Another major accrediting agency is the Health Care Financing Administration or HCFA. It is an agency under the federal Department of Health and Human Services. These regulations are legislated by public law to regulate reimbursement of Medicare and Medicaid funds and are different than the other voluntary accrediting programs above because of the direct funding implications. Changes in HCFA regulations are published in the *Federal Register*. The health care agency must comply with Title VI of the Civil Rights Act and participate in utilization reviews and external professional standards review of the organization besides maintaining compliance with the Medicare and/or Medicaid standards.

- Medicare focuses on an annual review and observation of the care patients receive who have services reimbursed by Medicare. Special staffing needs, the cleanliness and condition of the service delivery environment are also reviewed during Medicare surveys. Those services reimbursed by Medicare are determined by special need categories (e.g. Aid to Dependent Children, Social Security Disability...) and by potential recipients having a low income status. There are approximately 100 special need categories.
- Medicaid, is an annual survey of the care provided for all patients under 21 and over 65 who receive federal funds for medical services.

HOW DOES THE PRACTITIONER COMPLY WITH INTERNAL AND EXTERNAL STANDARDS?

In order for the practitioner to comply with internal service standards, she or he should have a current copy of the NTRS or ATRA Standards of Practice and Codes of Ethics. These internal standards prescribe the main duties and functions of the TR on the job, whether in a community or clinical setting. They are available from the respective national bodies (ATRA, 1993; NTRS, 1994). After reading the internal standards, which should take less than one hour, decide on which set of standards fit your services. Next analyze your department's achievement of the standards. Continuous improvement is an expectation because the agency's mission and society's needs are constantly in flux. ATRA's standards are helpful because of the Self-Scoring Guidelines that are also available. Both NTRS and ATRA standards address the following content areas:

NTRS		ATRA	
Standard 1.	Assessment	Standard 1.	Scope of Service
Standard 2.	Treatment Planning	Standard 2.	Mission, Purpose, Goals, Obj.
Standard 3.	Plan Implementation	Standard 3.	Individualized Treat./Prog. Plan
Standard 4.	Evaluation	Standard 4.	Documentation
Standard 5.	Discharge Planning	Standard 5.	Plan of Operation
Standard 6.	Recreation Services	Standard 6.	Personnel
Standard 7.	Ethical Conduct	Standard 7.	Ethical
Standard 8.	Written Plan of Operation	Standard 8.	Responsibilities
Standard 9.	Staff Credentials/ Development		Evaluation and Research
Standard 10.	Quality Improvement		
Standard 11.	Utilization Review		
Standard 12.	Program Evaluation/Research		

During your professional career as a therapeutic recreation specialist, you will need to address one or more of the previously listed external standards. To make it easier to understand the

external standards, read the prefaces or introductions, table of contents and review briefly how the standards are scored. If you are having difficulty using or understanding the manual, seek out someone in your agency who has taken part in the survey for the past few years and ask them questions. Usually, survey participants are willing to share their knowledge, especially after you have put effort toward studying the rules. You may also want to contact another TR practitioner at a similar facility in your city or state to discuss how he or she have designed their services to meet the standards.

As you can see there are a number of external accrediting bodies and as a practitioner you will need to be comfortable interacting with or preparing documentation routinely for surveyor's review. This contact has increased over the past few years. "Rehabilitation services" and their treatment outcomes have become even more important and so are increasingly included in the treatment practices reviewed during surveys. This has come about largely to our national professional efforts and consumer awareness of our services.

WHAT DOES AN EXTERNAL STANDARD LOOK LIKE?

The grid on the following pages (Table 1) contrasts some of the latest standards of CARF, JCAHO, HFCA, NTRS, ATRA on the functional category of "ASSESSMENTS" and contrasts how two different agencies might address this standard:

In comparing both the internal and external assessment standards on the grid, you will note the following similarities in ATRA, NTRS, JCAHO, CARF, HFCA requirements:

- an individualized assessment,
- documented in writing,
- within timeframes,
- generating baseline data (strengths/weaknesses/skills competencies/functional levels...),
- including assessment of physical, social, cognitive, behavioral, emotional, leisure/play categories,
- and written protocols/objectives to direct the assessment procedures.

TABLE 1

FUNCTION: ASSESSMENT	INTERNAL STANDARDS			EXTERNAL STANDARDS	
	ATRA	NTRS	JCAHO	CARE	HCFA
STANDARD	<p>1. The therapeutic recreation specialist conducts an individualized assessment to collect systematic, comprehensive and accurate data necessary to determine a course of action and subsequent individualized treatment plan.</p> <p>1.1 Structure Criteria</p> <p>1.1.1 The assessment process shall be documented within the department's written plan of operation. The process is clear, concise, has standardized procedures and timeframes for completion.</p> <p>1.1.2 The assessment process generates baseline data that identifies the patient's/client's strengths and limitations in the following functional areas: physical, cognitive, social, behavioral, emotional, leisure/play.</p> <p>1.1.3 The assessment is conducted by a therapeutic recreation specialist in a timely manner, in accordance with standards of regulatory agencies and/or treatment protocols and policies.</p> <p>1.2 Process Criteria</p> <p>The therapeutic recreation specialist:</p> <p>1.2.1 Informs the patient of his/her responsibilities in the assessment and seeks collaboration in the process. If the patient's/client's condition or ability prevents his/her involvement in the assessment, the TRS seeks involvement of family and/or significant others.</p>	<p>1. Scope of Service</p> <p>A. Treatment services are available which are goal-oriented and directed toward rehabilitation, amelioration and/or social functional behaviors. TR intervention targeting these functional behaviors inspects or otherwise inhibits participation in reasonable and customary leisure participation.</p> <p>Criteria</p> <p>1. Development and Implementation of Treatment Services</p> <p>a. There is a plan for assessing physical, emotional, cognitive and/or social behaviors.</p> <p>2. Content of Treatment Services</p> <p>a. Treatment services are designed to focus on TR interventions targeting specific physical, emotional, cognitive, and/or social functional behaviors.</p> <p>8. Leisure education services are available that are goal-oriented and directed toward the development of knowledge, attitudes, values, behaviors, skills, and resources related to socialization and leisure involvement. (Note: This may not apply for all clients).</p> <p>Criteria</p> <p>1. Development and Implementation of Leisure Education Services</p>	<p>SECTION 1 PATIENT FOCUSED FUNCTIONS—ASSESSMENT OF PATIENTS (7E) (AMH MANUAL) INITIAL SCREENING</p> <p>PE 1 Each individual's physical and psychological status and social functioning was assessed</p> <p>PE 1.4 The need for assessing the full range of the individual's functional status is determined.</p> <p>PE 1.5 An emotional and behavioral assessment of each individual is completed and entered in the clinical record.</p> <p>PE 1.5.2 Current emotional and behavioral functioning</p> <p>PE 1.5.2 In programs serving the severely and persistently mentally ill, assessment includes identification of the community resources currently used by the individual.</p> <p>PE.1.6.1 The psychosocial assessment includes information relating to:</p> <p>PE 1.6.1.2 Leisure and recreation;</p> <p>PE 1.6.1.3 The social, peer, group, and environment setting from which the individual comes;</p> <p>PE 1.6.1.4 Inpatient and residential programs and therapeutic foster care that serve children, adolescents, or the developmentally disabled, the physical health assessment includes</p> <p>PE 1.9.2.1 motor development and functioning;</p> <p>PE 1.9.2.1 sensorimotor functioning.</p> <p>PE 1.13 The scope and intensity of any further assessment, in accordance with the organization's mission and scope, are determined by:</p>	<p>DD INDIVIDUAL PROGRAM PLANNING</p> <p>Program plans should be individualized and designed by a team that establish goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served and should relate to the services and environment to which the person will be discharged.</p> <p>4. Assessment</p> <p>The organization should establish procedures for initial and ongoing assessment that:</p> <p>a. Provide for the identification of the strengths, abilities, needs, and preferences of the persons served.</p> <p>b. Include the desired outcomes and expectations, of the person served.</p> <p>c. Include the outcomes anticipated by the persons conducting the assessments</p> <p>d. Provide for the use of assistive technology, as needed, in the assessment process.</p> <p>e. Provide for the use of the assessment findings to direct the development of the individual plan for the persons served.</p> <p>f. Provide for the reporting of the assessment outcomes to appropriate personnel and to the persons served.</p> <p>g. Establish specific time frames for both initial and ongoing assessment.</p>	<p>MEDICAID 42 CFR Ch. IV (10-1-90 Edition)</p> <p>441.102 PLAN OF CARE FOR INSTITUTIONALIZED RECIPIENTS.</p> <p>(6) The Medicaid agency must provide for a recorded individual plan of treatment and care to ensure that the institutional care maintains the recipient at, or restores him to, the greatest possible degree of health and independent functioning.</p> <p>(8) The plan must include:</p> <p>(3) An initial review of the recipient's medical, psychiatric, and social needs</p> <p>(2) Periodic review of the medical, psychiatric and social needs.</p> <p>PLAN OF CARE</p> <p>456.10 Individual written plan of care.</p> <p>(b) The plan of care must include:</p> <p>(2) a description of the functional level of the individual;</p> <p>456.181 Reports of evaluations and plans of care.</p> <p>A written report of each evaluation and plan of care must be entered in the applicant's or recipient's record.</p>

TABLE 1 cont.

FUNCTION: ASSESSMENT	INTERNAL STANDARDS			EXTERNAL STANDARDS	
	ATRA	NTRS	JCAHO	CARE	HCFA
STANDARD	<p>1.2.2 Uses standardized assessment procedures including, as appropriate: structured interview, direct observation, performance testing, standardized testing, information from others, and/or review.</p> <p>1.2.3 Provides a summary of the assessment process that contains information relative to the patient's/client's strengths, patient's/client's limitations, analysis of assessment data, and summary of functional status.</p> <p>1.2.4 Based upon the analysis of assessment data, formulates clinical impressions and recommendations for treatment, referral for other services, or no service at all.</p> <p>1.2.5 Reports assessment findings to appropriate individuals to include the treatment team.</p> <p>1.2.6 Documents all relevant information regarding the assessment process within the patient/client record.</p> <p>1.3 Outcome Criteria</p> <p>The patient/client, family and/or significant other:</p> <p>1.3.1 Participates in the assessment process, to the extent possible.</p> <p>1.3.2 Complies with the assessment process.</p> <p>1.3.3 Benefits from the assessment process and should not incur adverse consequences from the assessment.</p>	<p>a. There is a plan for assessing knowledge, attitudes, values, behaviors, skills, barriers and resources related to socialization and leisure functioning.</p> <p>C. Recreation services are available that provide a variety of activities designed to meet client needs, competencies, aptitudes, and capabilities.</p> <p>Criteria</p> <p>1. Development and Implementation of Recreation Services</p> <p>a. There is a plan for assessing identifying goals and objectives, client leisure needs, interests, competencies and capabilities. This is sometimes referred to as a needs assessment or benefit-based management.</p> <p>IV DOCUMENTATION</p> <p>The therapeutic recreation specialist record specific information based on client assessment, involvement, and progress. Information pertaining to the client is recorded on a regular basis as determined by agency policy and procedures, and accrediting body standards.</p> <p>Criteria</p> <p>1. The individualized treatment/program plan is recorded in the client's records.</p> <p>Documentation includes:</p> <p>b. assessment and progress data</p>	<p>PE 1.15.1 the care setting</p> <p>PE 1.15.2 the individual's need and desire for care; and</p> <p>PE 1.15.3 response to previous care.</p> <p>PE 1.16.3 A developmental perspective in evaluating all aspects of the child's or adolescent's functioning is required. The evaluation(s) should include an assessment of the individual relative to normative development for his or her chronological age.</p> <p>PE 1.16.4 Whenever services are provided to a child or adolescent, a mechanism exists that coordinates and facilitates the family's or guardian's involvement through the assessment process. This mechanism includes an assessment of the individual's play and daily activities needs; and</p> <p>PE 1.17.2 The psychosocial assessment addresses (for MR/DD)</p> <p>PE 1.17.2.2 adaptive behavior, social functioning, and independent living skills, and</p> <p>PE 1.17.2.3 skills, talents, aptitudes, and interests in leisure activities.</p> <p>PE 1.17.5.2 The reassessment of social, emotional and behavioral, educational, vocational and cognitive functioning, as well as recreational need and when appropriate, legal needs, is conducted at regular intervals, at least annually, by the interdisciplinary team on an individual basis.</p> <p>REASSESSMENT</p> <p>PE 3 Each individual is reassessed</p> <p>PE 3.1 at regularly specified times related to the individual's course of treatment;</p> <p>PE 3.2 to determine the individual's response to treatment</p> <p>PE 3.3 when a significant change occurs in the individual's condition, and</p> <p>PE 3.4 when a significant change occurs in the individual's diagnosis.</p> <p>STRUCTURE SUPPORTING THE ASSESSMENT PROCESS</p> <p>PE 4 the activities that comprise the assessment function are defined in writing.</p> <p>PE 4.1 Each discipline's scope of assessment is defined in writing.</p>	<p>482.61 CONDITION OF PARTICIPATION; SPECIAL MEDICAL RECORDS REQUIREMENTS FOR PSYCHIATRIC HOSPITALS</p> <p>(a) Standard: Development of assessment/diagnostic data.</p> <p>(4) The social service records, including reports of interviews with patients, family members, and other, must provide an assessment of home plans, family attitudes, and community resource contacts as well as social history.</p> <p>(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.</p>	

Several other concepts in the assessment standards are addressed:

- a. involving the patient and significant other or family,
- b. taking into consideration environment, setting, or home plans of the patient, and
- c. and the involvement of a multi-disciplinary team approach.

While not uniformly addressed in the assessment section, these concepts are addressed by all of the accrediting agencies somewhere in other chapters or sections of the external standards.

Given the almost uniformity of expectations for assessments, will agencies uniformly have structures, processes, and outcome criteria that also look similar? A random telephone interview with two different client-based agencies provided the following information to this question. Below is an example of a state psychiatric hospital identifying structures (in italics) used to comply with the JCAHO, HCFA, ATRA and NTRS assessment standards:

Policy On: Therapeutic Recreation Assessment

Purpose: To define the standards for completion of therapeutic recreation assessments to determine appropriate services.

Policy: All patients will be assessed by the third day of hospitalization and an individualized treatment plan will be recommended for any Therapeutic Recreation services.

Procedures:

- 1. All patients will be assessed by the third day of hospitalization and written on Form 412.2 and placed in the patient's assessment section of the chart.
- 2. A corroborating progress note will identify the date and time of completion and filing in the chart.
- 3. All assessments will identify how the information was gathered and follow the TR protocol for completing the assessment, which includes the assessment of cognitive, physical, leisure, intra- and inter-communication functioning.
- 4. All assessments will incorporate the patient's goal as part of the treatment recommendations.
- 5. All assessments will identify specific assets and deficits/age-appropriate functional levels of the patient and address these in the recommendations section of the assessment.

6. All assessments incorporate family/significant other involvement, and awareness of the discharge living environment if possible.

7. All pages will contain the patient's name and hospitalization number or stamped with the patient's hospital card prior to filing in the chart.

8. All assessments will be signed by the full professional signature of a Certified Therapeutic Recreation Specialist and dated.

9. Interns completing the assessment as part of their pre-professional training requirements will sign with their full signature and date it, as well as have the assessment co-signed and dated by the supervising therapist.

Processes used by this agency to meet the JCAHO, HCFA, ATRA and NTRS standards are:

a. Therapists determine the intensity of the assessment balancing time and patient needs (example: the difference between the case load on a evaluation team versus a long-term team).

b. The determination by the TRs of the standardized protocol for filing out the TR assessment reporting form (including how to complete the assessment, as well as the age appropriate tools to be used in the assessment.)

c. Interagency approval and recognition of the TR assessment. Peer review of finished assessments.

d. Approval by the hospital medical records committee (a sub-committee of the hospital's Medical Staff) of all the forms and protocols.

e. Inclusion in the TR department's and hospital's quality improvement monitoring for timeliness and quality.

f. Annual work evaluations of the quality of the therapist completing the assessment.

g. Utilization review of the continued appropriateness of the TR assessment as a service (example: questioning short-term stays under 3 days the appropriateness of an assessment that could possibly take 3-4 hours to complete.)

h. In the second agency (a community therapeutic recreation program) staff identified structures they used for assessments:

- a. Client's/client's family's request for help for the client with leisure and social needs,
 - b. Written assessment only upon request, otherwise verbal recommendations were given,
 - c. The assessment focused on leisure, social, wellness recommendations however, the cognitive, emotional, physical, medical capabilities were taken into consideration as the TR service was provided or recommendations were made.
- The community TR program's processes for their services included:

- a. Introducing themselves to all new participants,
- b. Briefly explaining their services, the facilities and policies to all new participants,
- c. Asking the client or care giver any special requests for services,
- d. Observing the participants successes and failures and making supportive, helpful suggestions to met their expressed or unexpressed needs.

While the structures and processes utilized by both the clinical and community agencies were noticeably different (e.g. formality versus informality, depth of the assessment . . .), in both scenarios the standards of practice were met.

WHAT ARE THE CONSEQUENCES OF NON-COMPLIANCE WITH INTERNAL OR EXTERNAL STANDARDS?

Consequences of non-compliance with internal standards from ATRA or NTRS could be:

- a. Informed consumers might sue because treatment was deemed substandard, lacked assessment appropriateness, or they suffered harm.
- b. A Certified Therapeutic Recreation Specialist might suffer pay reduction if a disciplinary action is instituted at their facility in an attempt to correct the problem.

- c. The National Council for Therapeutic Recreation Certification (NCTRC) could possibly hear the charges and the therapist could ultimately lose his/her national certification.

At this time internal standards actions are rare, except for those occurring at the agency level. External actions happen more frequently. Consequences of non-compliance with external standards (CAHO, CARF, & HCFA) might place in jeopardy the hospital's overall accreditation. Medicaid/Medicare revenue from HCFA might be lost because of an agency's or department's pattern of delivering inappropriate or incorrect treatment. Non-compliance findings by one external agency are often shared with other agencies (CAHO with HCFA or vice versa) and can trigger a re-survey/early survey/continued monitoring by the accrediting agency. This may entail the collection of extra data, an expenditure of a large amount of time on behalf of agency's administration or therapists to justify their treatment practices, managers demoted or fired, or a loss in revenue. Also some external agencies can fine the offending agency for non-compliance (e.g. the state health department.) In preparing for a survey predicting difficulty with meeting the standards can be used as leverage to gain more resources. Also, the opposite could occur, a department/agency could use partial failure of a survey to make the argument for more resources to do the job in a quality manner and according to the standards.

WHAT DO PRACTITIONERS THINK NOW?

The authors of this chapter conducted a survey in the spring of 1995 to determine the utilization and relevancy of TR standards of practice from the perspective of current practitioners. This field based survey draws from a selective sample. The results of the survey are based on a sample of 77 respondents who were members of the National Therapeutic Recreation Society and the American Therapeutic Recreation Association. Nearly all (95%) of the respondents were Certified Therapeutic Recreation Specialists and averaged eleven years in the profession. One fourth of the respondents worked in one a person department, 15% indicated their department size was four persons and 13% worked in two person

programs. All 77 respondents completed the "Therapeutic Recreation Standard of Practice Survey," which was made up of 13 questions as indicated in Table 2.

A broad range of populations were represented by survey respondents and close in distribution. The following were the largest populations represented: 15% mental health, 13% physical

TABLE 2
STANDARDS OF PRACTICE SURVEY

1. Population Served—Check all that apply.
 - a. Physical rehabilitation
 - b. Eating disorders
 - c. Community P & R
 - d. Sensory impaired
 - e. Long-term care
 - f. Substance abuse
 - g. Mental health
 - h. Transitional care
 - i. Developmental disabilities
 - j. General medical/surgical
 - k. Pediatrics
 - l. Other _____
2. Describe work situation: Type of agency, funding source, position, clients served.
3. How long have you been at present and how many as a TR?
4. How many TR's are certified by the following: JCAHO, CARF, HCFA, None, Other
5. Is your program accredited by the following: JCAHO, CARF, HCFA, None, Other
6. Please indicate the standards of practice that guide your delivery of treatment/service: ATRA, NTRS, None, Other _____
7. Do you implement all of the standards recommended by ATRA? NTRS?
8. Which standards do you feel you are best at implementing? Check all that apply.

ATRA:

- a. Assessment
- b. Treatment planning
- c. Plan implementation
- d. Evaluation
- e. Discharge planning
- f. Recreation services
- g. Ethical conduct
- h. Written plan of operation
- i. Staff credentials/development
- j. Quality improvement
- k. Utilization review
- l. Program eval./research operation

NTRS:

- a. Scope of service
- b. Mission, purpose
- c. Indiv. tx./program plan
- d. Documentation
- e. Plan of operation
- f. Personnel qualifications
- g. Ethical responsibilities
- h. Evaluation and research
- 9. Check all standards that are difficult for you to implementing? Same choices as in #8.
 - a. Do not have the standards
 - b. Do not know where to get them.
 - c. I do a good job without them.
 - d. Not required by agency
 - e. Not required by department
 - f. Unnecessary
 - g. Staff
 - h. Time
 - i. Cost
 - j. Other _____
- 10. Check barriers in implementing TR standards of practice.
 - a. Do not have the standards
 - b. Do not know where to get them.
 - c. I do a good job without them.
 - d. Not required by agency
 - e. Not required by department
 - f. Unnecessary
 - g. Staff
 - h. Time
 - i. Cost
 - j. Other _____

11. Do you provide staff training to implement the standards of practice?
12. After having answered all the above questions, please comment on how relevant you feel the standards are in relation to your services. Scale 1—Completely irrelevant to 5—Highly relevant
13. What would make the standards more relevant to your delivery of services?

rehabilitation, 10% developmental disabilities, 10% substance abuse, and 9% long-term care. Most persons surveyed delivered therapeutic recreation services in an inpatient program (53%), followed in rank by community programs (27%) and then outpatient programs (20%). Table 3 represents the percentage of these programs accredited by external accrediting bodies:

Those surveyed utilizing both ATRA "Standards for the Practice of Therapeutic Recreation Service" and NTRS "Standards of Practice for The Therapeutic Recreation Service" were 29% of the respondents. Only 22% indicated they use ATRA standards exclusively and 39% use only NTRS standards, while 10% do not use any professional internal standards. Survey participants asked if they implemented all of ATRA and/or NTRS standards of practice, 49% answered no, while 46% indicated that they implemented them all. Table 4 summarizes participants response to ATRA and NTRS's standards implemented the most at their agency.

TABLE 3
EXTERNAL ACCREDITING BODIES

JCAHO	40%
HCFA	16%
CARF	14%
NONE	18%
OTHER	11%

**TABLE 4
NTRS AND ATRA STANDARDS
IMPLEMENTED THE MOST**

NTRS	ATRA
1. Mission, Purpose, Goals, and Objectives	1. Assessment
2. Ethical Responsibility	2. Treatment plan
3. Scope of Service	3. Plan Implementation
4. Individualized Program /Treatment Plan	4. Ethical Conduct
5. Documentation	5. Recreation Services

Therapeutic Recreation practitioners found the following ATRA/NTRS standards (Table 5) the most difficult to implement (in order of difficulty:

**TABLE 5
STANDARDS MOST DIFFICULT TO IMPLEMENT**

ATRA	NTRS
1. Program Evaluation and Research	1. Evaluation
2. Utilization Review	2. Personnel Qualifications
3. Staff Credentials and Development	3. Plan of Operation
4. Quality Improvement	

Even though 83% of all survey respondents indicated that standards of practice were relevant, only 46% had implemented ATRA or NTRS standards of practice. Only half of the respondents provided staff training to implement the standards of practice. This dichotomy between thinking about the worth of standards of practice and engaging in real actions of implementation of the standards will be explored more fully in the next section. Barriers experienced in implementing either NTRS or ATRA standards of practices are reported in Table 6.

**TABLE 6
BARRIERS EXPERIENCED IN IMPLEMENTING
TR STANDARDS OF PRACTICE**

- Time 26%
- Not required by agency 21 %
- Staff 21%
- Cost 9%
- Internal standards unnecessary 3%
- Lacks access to standards 3%
- Staff do a good job without them 3%
- Don't know where to get them < 1%

As indicated in Table 6, "time" was the most limiting constraint (26%). This factor was identified for many reasons:

- standards were considered less of a priority both by administration and employee,
- less emphasis now on standards in a managed care environment and more on non-billable activities,
- less emphasis on paperwork,
- limited staff and a resulting conflict between priorities of quality versus time.

Identified "staff" issues (21%) included comments concerning lack of agency/program/department leadership, priorities are changing due to "revolving door" clientele, hiring non-Certified Therapeutic Recreation Specialists, lack of understanding of the standards and standards not reinforced by agency or the TR department. Comments related to "cost" included a decrease in financial resources for staff training and development of standards in the program and less reimbursement for documenting activities.

Despite the barriers in implementing either ATRA/NTRS standards of practice, most (82%) respondents expressed that standards of practice are relevant to their services. First of all, external agencies, such as JCAHO, CARF, HCCA, are placing increased emphasis on treatment outcomes, professional competency and quality improvement. These agencies are now also including expectations for TR services in their accreditation standards. This is largely due to the involvement of therapeutic recreation professional organizations such as NTRS and ATRA, appointing representatives to serve on task forces within these external agencies. This representation has facilitated education of the mission, purpose, goals, and outcomes of therapeutic recreation practices. In addition, practitioners in therapeutic recreation indicated that by implementing standards of practice they could assure that services would have a universal focus and uniformity. However, this is complicated by the profession having two sets of standards of practice and provokes questions of unity of mission, focus, outcomes, for populations served in therapeutic recreation services. Concurrently, the consumers of health care services are demanding more accountability. Whether it is the client, their family or the third-party payer requesting accountability in safety, efficiency, effectiveness, and cost containment, these outcomes are important considerations the profession can not afford to ignore. Therefore, standards of practice are the foundation for providing quality services in our profession.

HOW CAN THE RELEVANCY OF TR STANDARDS OF PRACTICE BE ENHANCED?

Action needs to be taken in the following areas—In undergraduate or graduate therapeutic recreation curriculums:

1. Teach the purpose of the standards.
2. Teach skills that will allow students to achieve the standards (e.g. research and evaluation methods).
3. Encourage more research supporting the efficacy of therapeutic recreation.
4. Utilize fieldwork experiences to provide practice in achieving TR standards of practice.
5. Universities need to affiliate with internship placement sites who can demonstrate meeting the TR standards of practice.

By the therapeutic recreation practitioner:

1. Adopt and implement one set of TR standards of practice.
2. Provide training to agency staff within the department on the implementation of TR standards of practice.
3. Educate your consumers about TR standards of practice.
4. Educate other professionals in your facility about therapeutic recreation practices.
5. Encourage dialogue with accreditation surveyors about the TR functions and processes in your facility.

By the therapeutic recreation professional organization:

1. Continue to revise and update the standards of practice with practitioners.
2. Continue representation and educational efforts through inclusion of therapeutic recreation representatives on national task forces within external accrediting bodies.
3. Provide educational opportunities at local, state and national conferences on interpretation and implementation of the standards of practice.
4. Develop one universal set of standards applicable to community and clinical settings.
5. Collaborate with National Council for Certification of Therapeutic Recreation (NCTRC) to enforce achievement of the standards.

By the consumer of therapeutic recreation services:

1. Request reliability, efficacy, safety, competent staff when TR services are provided.
2. Encourage consumer advocacy for TR services.

As identified in previous work by Smith and Land (1989), Riley (1987), Van Andel (1981) and the authors of this chapter, the following points are recommended for further standard of practice studies:

1. Continue educational involvement through national organizations and accrediting bodies on therapeutic recreation services.
2. Explore the feasibility of developing a universal set of standards that reflect both community and clinical practices.
3. Update and promote flexibility in the standards to address a variety of settings and a diversity of clientele.
4. Align standards of practices with community TR practices.
5. Determine the educational practices needed in order to provide students with the skills to address the most difficult to implement standards of practice.

SUMMARY

This chapter discussed the internal and external standards of practices and their relevancy to the practice of therapeutic recreation. A sample of a particular standard of practice was given and how each of the accrediting bodies addressed this standard. The link between the practice of therapeutic recreation and the relevancy of professional standards now and in the future was explored and discussed from the viewpoint of a survey by therapeutic recreation practitioners.

The intent of this chapter has been to raise questions and issues to be considered (such as: the formulation of a unified standard of practice for therapeutic recreation). As professionals in a field striving for visibility and accountability we must unify and continue to seek out ways to validate our profession's mission.

Through universal and continued use of professional standards of practice we will achieve this goal. If each practitioner would personally and professionally commit to achieve the standards of practice as set forth by the profession, then yes, standards of practice are relevant. If not, then our profession will continue into the next decade with the struggles it faces today.

STUDY QUESTIONS

1. Identify a current single example of a standard of practice. Does this standard comply with the intent of standards? Why is this standard critical to the performance of the professional? If one were to violate the standard, what would be the resultant effects? Would there be a basis for litigation?
2. Why do we have two sets of standards of practice? Compare and contrast the ATRA and NTRS standards of practice. Are there other internal standards we must comply with in different settings?
3. Visit a therapeutic recreation professional in a hospital setting and review his/her perception of the JCAHO standards as they relate to therapeutic recreation. Are they specific enough? Do they really require a minimum in practice that is realistic? What, in the opinion of the practitioner, should be done to change the external standards?
4. Discuss the potential consequences of being non-compliant to either the internal or external standards of practice. What implications (personal, profession wide and legal) seem obvious?
5. Examine why some standards are more difficult to implement than others (e.g. program evaluation and research, utilization review, etc.). Discuss how an agency and its staff could increase their compliance.

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