STANDARDS FOR THE PRACTICE OF RECREATIONAL THERAPY & SELF-ASSESSMENT GUIDE

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The American Therapeutic Recreation Association (ATRA) was founded in 1984 and is the national membership organization representing the interests and needs of recreational therapists who work in health care and human service settings. The mission of ATRA is to serve as a member-driven association that collectively supports the recreational therapy profession. A primary focus of ATRA is to advance the recreational therapy profession as a cost-effective, evidence-based treatment service that produces outcomes that are valued by patients and other stakeholders.

**ATRA Definition of Recreational Therapy**

“Recreational Therapy” means a treatment service designed to restore, remediate and rehabilitate a person’s level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

ATRA 2009

The ATRA definition of recreational therapy is consistent with definitions of recreational therapy by the U.S. Department of Labor, Bureau of Labor Statistics (See Occupational Outlook Handbook); the American Medical Association (See AMA Health Careers Directory); accreditation standards of the Joint Commission (JC) and the Commission on Accreditation of Rehabilitation Facilities (CARF); regulations of the Centers for Medicare and Medicaid Services (CMS) including CMS Conditions of Participation (CoP) and the World Health Organization’s (WHO) International Classification of Functioning (ICF).
A primary responsibility of a professional association is to provide guidance and direction to members, the profession and stakeholders with respect to qualifications, competencies, practice and conduct. ATRA has played a leading role in the development of practice standards since its inception in 1984.

In 1991, with the first publication of the *Standards for the Practice of Therapeutic Recreation*, a comprehensive set of practice guidelines were established for the profession. The ATRA standards of practice uniquely incorporated structure, process and outcome criteria into twelve standards describing professional practice. Two years later, the ATRA standards of practice was expanded to include an evaluation component designed to enable practitioners to “self-evaluate” both the quality and scope of their professional practice. The *ATRA Standards for the Practice of Therapeutic Recreation and Self Assessment Guide* (1993) proved to be an invaluable resource to scores of professionals who have aligned their practice with the ATRA standards of practice. The *ATRA Standards for the Practice of Therapeutic Recreation & Self-Assessment Guide, Revised 2000*, provided significant revisions including criteria for the practice of therapeutic recreation assistants. Included were tools and methods for collecting data to be used in the self-assessment of compliance with the standards of practice. The revisions made in 2000 also included a review of language and content to account for cultural sensitivity and improve consistency with the standards of regulatory agencies. Documentation and management audits, competency assessment and performance appraisal instruments were included, as well as outcome assessment information, which included a sample patient satisfaction survey, to assist in data collection in order to support effective evaluation of compliance with the standards and criteria. A Patient’s/Client’s Bill of Rights was also included in the 2000 Edition.

ATRA received much positive feedback from recreational therapy, allied health and health care practitioners about the quality of the *ATRA Standards for the Practice of Therapeutic Recreation & Self-Assessment Guide, Revised 2000* and the consistency of the ATRA standards of practice with those of health care accreditation agencies including Joint Commission (JC) and the Commission on Accreditation of Rehabilitation Facilities (CARF). Recreational therapists provided positive feedback on the usefulness of the criteria for assistants, the data collection instruments and their enhanced ability to collect data to effectively evaluate and improve compliance with the standards of practice. Since 2000 the ATRA Standards of Practice Committee has trained thousands of practitioners regarding the value of using the ATRA standards of practice to improve consistency of compliance with the standards, quality of services provided and patient/client outcomes achieved.

The ATRA Standards of Practice Committee monitors changes in the focus and delivery of health care and human services in order to provide professionals with standards of practice that reflect and comply with regulatory requirements for health care and human service disciplines. In order for practice standards to maintain a sense of value and acceptance, they must reflect the changing nature of the profession and the environment in which it is practiced. Since 2000 a major focus in *safe and effective* health care practice has developed in the health care industry. This major shift in awareness, focus and policy includes a significant effort to improve patient/client and stakeholder satisfaction and valuing of outcomes achieved through evidence-based treatment, while reducing errors and harm. The publication, *To Err is Human*, and subsequent similar publications, are credited with initiating increased public awareness and the focus of policy makers on the patient/client harm caused by errors that occur in health care practice and the significant cost associated with these errors (IOM, 1999). A result of this increased awareness by the public, policy makers and regulatory agencies, is the expectation that health care should be *safe, effective* and more consistently use *evidence* to treat patients effectively. These practices restore and increase patient/client trust, increase satisfaction, manage costs and consistently and predictably achieve valued patient/client outcomes. This change of awareness and focus in
health care has resulted in an increased focus on safe and effective treatment and care in the standards of regulatory agencies. Therefore, it is necessary to incorporate this current focus on safe and effective practice into recreational therapy treatment and care to reduce potential or actual harm and to increase satisfaction and valuing of outcomes by stakeholders.

Much gratitude is expressed to the many practitioners who dedicate their careers to safe and effective recreational therapy practice, based upon the assessed compliance with the ATRA Standards for the Practice of Recreational Therapy & Self-Assessment Guide. Recreational therapy practice based on the standards of practice has contributed directly and indirectly to the evolution of recreational therapy practice and has influenced the development of these revised standards of practice. Appreciation is expressed to the many professionals who have attended presentations and provided valuable information that has contributed to revisions in this document. Appreciation is also expressed to those who participated in the Standards of Practice Membership Field Review and Survey. Analysis of the survey data and respondents’ feedback were used to make final revisions to the content of the revised standards of practice. Gratitude is also expressed to the ATRA Board of Directors for their vision and support of this revision of the ATRA standards of practice and to Diane Skalko for her review and contributions to the revisions. Finally, gratitude is expressed to Richard Williams for his time and effort with the SOP Membership Field Review and Survey and to Bryan McCormick and Gretchen Snethen for completing the analysis of the responses to the SOP Membership Field Review and Survey.

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INTRODUCTION

This revision of the ATRA standards of practice includes both subtle and significant changes in the content and language of the standards, criteria and evaluation tools. The adoption of the definition of recreational therapy by the ATRA Board of Directors in 2009 provided clear direction to the need to focus the ATRA standards of practice for recreational therapy. This change in focus is both timely and appropriate so the ATRA standards of practice can be relevant and consistent with practice expectations in health care and human service agencies where most recreational therapists work. As a result of this change in focus, this revision of the ATRA standards of practice is titled ATRA Standards for the Practice of Recreational Therapy & Self-Assessment Guide.

Recreational Therapy is practiced in a variety of health care and human service settings (e.g. clinical settings include hospitals, mental health facilities, rehabilitation facilities, skilled nursing facilities, outpatient, home care and residential settings; human service settings include camps, group homes, public schools, public recreation settings, etc.). In these settings recreational therapy must be practiced in compliance with state and federal laws and regulations, requirements of accrediting and regulatory agencies, payers and employer policies and procedures, as well as professional standards of practice and codes of ethics. The ATRA Standards for the Practice of Recreational Therapy & Self-Assessment Guide provides guidance for safe and effective recreational therapy practice consistent with the ATRA definition of recreational therapy in the various settings where recreational therapy is practiced. Changes in the content of standards and criteria were made to significantly improve the consistency of the ATRA Standards for the Practice of Recreational Therapy with standards of regulatory agencies, including JC, CARF and CMS, and the current focus of the health care industry on safe, effective, evidence-based treatment and care provided by qualified and competent professionals. Some of the changes in this revision of the ATRA standards of practice are:

- A change in the focus and organization of the standards, from direct practice and management of practice standards, to one set of standards is more consistent with how health care and human services are organized and delivered by professionals who integrate direct practice and management of practice into their work. For example, in health care agencies, treatment teams are more often organized by program, service line or product line management models and practitioners are expected to effectively integrate direct practice and management of practice into their work.

- A modification to Standard 1 was made to recognize that recreational therapists in clinical settings receive and respond to requests, including referrals and physician orders, and complete an individualized assessment in order to design an individualized plan for intervention. In human service agencies admission to an agency or program or a referral for service provision may initiate recreational therapy, instead of physician orders. In health care agencies, which are regulated by CMS, active treatment is defined and regulated by CMS. CMS requires physician orders in the criteria that define active treatment. The change in Standard 1 makes the ATRA standards of practice consistent with the routine and customary practice of treatment disciplines in health care and human service settings and includes language for compliance with the CMS requirements for recreational therapy provided as active treatment. It is very important to note that the criterion 1.1.1. for Standard 1 requires that the policy and procedures define the process for receiving and responding to requests, including referrals and physician orders, for recreational therapy assessment and treatment, in compliance with the state and federal laws and regulations as well as the requirements of the regulatory and accreditation requirements of the agencies that regulate the specific setting where recreational therapy is practiced. For example, if an agency, such as a public school or an adult day program, is not regulated by CMS, physician orders may not be required before initiating recreational therapy. Even in clinical settings, such as hospitals or skilled nursing facilities,
physician orders may not be required for the provision of activities or recreation for persons with illnesses or disabling conditions. CMS does require skilled therapies, including recreational therapy, to have physician orders when providing active treatment. For safe and effective recreational therapy practice and effective risk management, physician orders and clinical supervision are recommended in all settings where recreational therapy (not recreation or activities) is provided.

With the change in focus of the standards of practice to recreational therapy practice, the standards of practice are now consistent with the ATRA definition of recreational therapy as well as the Centers for Medicare and Medicaid Services (CMS) requirements for recreational therapy provided as active treatment and CMS requirements for skilled therapy which are different from activities or recreation for persons with illnesses or disabling conditions. These terms are defined in the glossary. The standards of practice are equally applicable to recreational therapy practice in human service settings since structure criteria of the standards require that policies and procedures define recreational therapy practice in compliance with the state and federal laws and regulations as well as the requirements of the regulatory and accreditation requirements of the agencies that regulate the specific setting where recreational therapy is practiced.

An expansion of standards for recreational therapy assistants (RTA) was added to all twelve standards of practice to account for those agencies with recreational therapy assistants and to provide guidance and consistency of practice in health care and human service agencies. The definition of recreational therapy assistant in the glossary defines the qualifications of recreational therapy assistants. When the definition of an RTA is used in concert with the standards and criteria for recreational therapy assistants, the appropriate qualifications, role and functions of recreational therapy assistants in assisting the recreational therapist to provide treatment and care with necessary clinical supervision is much better described than the previous version of the standards of practice.

A change was made in the language and content of the standards of practice to reflect the increased focus on safe and effective, evidence-based recreational therapy treatment and care to improve consistency with standards of regulatory agencies. The use of the terms and phrase “treatment and care” are consistent with JC terminology. While the term “treatment” is consistently used throughout the document for consistency with the ATRA definition as well as standards and requirements of accrediting and regulatory agencies, recreational therapists practicing in human service settings may use terms more consistent with their setting such as “individualized program plan” or “individualized educational plan” as appropriate. The content of the standards and criteria should be appropriately applied in all settings as the basis of safe and effective recreational therapy practice.

A new Standard 6, Prevention, Safety Planning and Risk Management was added to improve consistency with JC, CARF, CMS standards and to improve consistency with the ATRA and CMS definitions of recreational therapy as a treatment service. Standard 6 now has a current and appropriate focus on how recreational therapists must practice with a focus on prevention, safety and risk management to improve consistency with the same focus of health care and human service agencies. Standard 2 Treatment Planning and Standard 3, Plan Implementation, describes the use of treatment interventions which may include the use of recreation activities as a treatment modality. Content from the original Standard 6, Recreation, was removed for the following reasons: the revised Standards of Practice focuses on recreational therapy, which is consistent with requirements of regulatory agencies; regulatory agencies have
dropped references to recreation services in acute care settings due to the higher levels of patient acuity and shorter lengths of stay; the standards of practice do not prescribe or define standards for any specific intervention, so if a recreation activity is used as a treatment intervention it would be covered by Standard 2 (Treatment Planning) and Standard 3 (Plan Implementation); and relevant content of the old Standard 6 (6.1.2, 6.1.3 page 19, ATRA 2000) was included in the new Standard 6.

Standard 8 delineates requirements for a Written Plan of Operation (policy and procedures) that governs and directs recreational therapy practice to be in compliance with state and federal laws and regulations, requirements of regulatory and accrediting agencies, payers, policies and procedures of employers and professional standards of practice.

A revision of the content of the Documentation and Management Audits was included to improve the scope and focus of the audits. An Outcomes Audit was developed to improve the focus of evaluating outcomes the patient/client receives from recreational therapy treatment and care.

A review of all standards and all components of the standards of practice was completed and revisions were made as necessary to assure consistency with requirements and guidelines of regulatory agencies and the focus on recreational therapy practice.

The revisions made to the standards of practice and the revised focus to recreational therapy practice establishes the ATRA Standards for the Practice of Recreational Therapy & Self-Assessment Guide as a contemporary standards of practice document that is current with the focus and priorities of the health care industry, as well as human service agencies. The revisions of the standards of practice are built upon the literature review and development, field testing and practitioner consensus that has been the foundation for the ATRA standards of practice. In addition, the ATRA Standards for the Practice of Recreational Therapy & Self-Assessment Guide compliments other ATRA publications including the ATRA Guidelines for Competency Assessment and Curriculum Planning for Recreational Therapy Practice; Recreational Therapy: A Cost Beneficial Option; Summary of Health Outcomes in Recreational Therapy; and Recreational Therapy: A Viable Option in Rehabilitation that describe competencies and benefits of recreational therapy. The ATRA Standards for the Practice of Recreational Therapy & Self-Assessment Guide is the essential guide to, reference for and description of safe and effective recreational therapy treatment and care. Effective use of the ATRA standards of practice will result in improved consistency and predictability of valued patient/client outcomes achieved.
The ATRA Standards for the Practice of Recreational Therapy provides standards for safe, effective and quality practice by recreational therapy professionals and paraprofessionals. These standards and criteria and the self-assessment guide are designed to assist the recreational therapy professional to assure the systematic provision of safe, effective and quality recreational therapy treatment and care that results in outcomes, that are achieved on a consistent and predictable basis and valued by stakeholders. These standards of practice are not intended to provide standards for the provision of recreation or patient activities intended for the general well-being of the patient/client.

Structure and Format

The ATRA Standards for the Practice of Recreational Therapy and Self-Assessment Guide was written in a format that provides a comprehensive description of recreational therapy practice. The format presents each standard, followed by criteria identifying structure, process and outcome content. The structure criteria reflect the parameters of practice (e.g., facilities or resources) to be measured. The process criteria focus on the provision of recreational therapy services (e.g., practitioner-patient/client interaction, intervention strategies) by qualified and competent recreational therapy professionals and paraprofessionals. The outcome criteria reflect the achievement or change in the patient's/client's condition (e.g., improved functional level, consequences to health or independence, satisfaction, etc.) to be measured. These standards are designed to be universal to recreational therapy practice and are not intended to be specific to service setting or patient/client population. For example, the standards do not attempt to establish time frames for documentation since these vary among agencies. The standards require that the written plan of operation (policy and procedure manuals) specify the time frames for recreational therapy documentation that meet facility, accreditation and regulatory agency standards and requirements. The same principle applies with regards to requests to initiate recreational therapy, including referrals and physician orders. In human service agencies a referral or admission to the agency or program may initiate recreational therapy and intervention, but in clinical settings physician orders and supervision are required by CMS for recreational therapy provided as active treatment. However, requiring physician orders is a good practice for all to follow for effective risk management.

Scope of Service

The standards and criteria reflect the common scope of recreational therapy practice performed by recreational therapists and recreational therapy assistants involved in clinical practice in health care and human service agencies. The standards and guidelines do not attempt to specify the resources needed for practice with a specific patient population or in a specific health care or human service agency, but do specify the structures, process and outcomes needed for safe and effective recreational therapy practice that would require appropriate resources. The amount of resources available defines and limits the amount of recreational therapy treatment and care that can be provided in accordance with the standards and criteria. For example, the Standards of Practice Committee is frequently asked about a recommended caseload or the ratio of therapists to patients/clients. A specific ratio cannot be required by these standards because the number and type of resources necessary to deliver recreational therapy varies depending on the type of intervention (e.g., community reintegration versus assertiveness training), frequency and duration (one hour of treatment/day for seven days) and intensity of service (e.g., acute care versus rehabilitative care or individualized versus group treatment) required to reach a specific patient/client outcome in a particular agency. The standards require that practitioners specify in their written plan of operation (policy and procedures manuals), the resources necessary
to provide treatment in accordance with the standards of practice and the amount of treatment that can be provided with the available resources. Adequate staffing is necessary to provide treatment services. Regulatory agencies, insurance companies and health care providers understand that recreational therapists must use resources available for treatment appropriately and effectively to reach the desired patient/client outcomes. Resources (including staff) that are not used effectively and appropriately, contributes to increased risk, decreased safety and diminished likelihood that valued patient outcomes will be consistently achieved.

By requiring written policies and procedures for scope of assessment and scope of service descriptions, recreational therapists and their supervisors must consider patient outcome priorities and the resources necessary to reach these outcomes. Consistent with JC and standards and requirements of other regulatory agencies, the ATRA Standards for the Practice of Recreational Therapy require policies and procedures for assessment and treatment/program plans. Such policies and procedures will enable the recreational therapist to define the resources necessary for effective provision of treatment consistent with priorities for patient/client outcomes given the specific healthcare or human service setting. The level of available resources will have a significant influence on the quantity and type of treatment that can be provided in compliance with these standards. Depending on a careful and specific analysis of all of these factors, caseloads for providing treatment may range from six to fifteen patients/clients per therapist depending upon many factors including the complexity of the diagnoses or disabling conditions, the acuity level of the patients served, the intensity of the treatment setting, etc.

How to Use the Self-Assessment Guide

Compliance with the ATRA Standards for the Practice of Recreational Therapy and Self-Assessment Guide can help to improve the quality of recreational therapy practice and the degree to which treatment outcomes are consistently and predictably achieved. Through self-assessment and quality improvement planning by the recreational therapist, compliance with the standards will be improved. The recreational therapy profession is now challenged to adhere to these standards and to initiate self-assessments to evaluate the compliance with the standards of practice and to develop effective quality improvement plans to improve compliance. The ATRA Standards for the Practice of Recreational Therapy and Self-Assessment Guide facilitates the monitoring and evaluation of aspects of recreational therapy practice deemed essential to the provision of quality services and the achievement of desired and valued patient/client outcomes. The Self-Assessment Guide is designed to be used for self-assessment to evaluate compliance of recreational therapy practice with the ATRA Standards for the Practice of Recreational Therapy and to determine opportunities for improving compliance with the standards. Compliance with the ATRA Standards for the Practice of Recreational Therapy will result in more consistent and higher quality care for the patient/client.

Field testing has shown that a complete self-assessment of recreational therapy practice should be planned with sufficient time to complete each of the data collection instruments (Documentation Audit, Management Audit, Outcomes Audit), with a reasonable and representative sample, to effectively and accurately assess performance. For example, a minimum sample size of twenty to thirty patient/client records should be used for the documentation audit of each recreational therapist. This can be done by randomly selecting five patient/client records per quarter for four quarters of the year. If the data collection using the instruments included in the appendices of the Standards for the Practice of Recreational Therapy can be included in the routine quality assessment/improvement activities, the data for a comprehensive evaluation can be more easily collected.
Once data are collected, the Scoring Summary Worksheet can be completed and a percentage of compliance score can be calculated. By using the data collection instruments and completing a scoring summary, opportunities for improved treatment and care are documented and can be used to develop a quality improvement plan designed to improve compliance with the Standards for the Practice of Recreational Therapy.

Prior to initiating a self-assessment, a careful review of the standards, data sources, data collection instruments and scoring methodology is suggested to determine the sources of documentation for rating the degree of compliance with the standards. For efficiency, once the data collection is completed on all aspects of the self-assessment, it is suggested that all audit summaries and materials used (i.e. policy and procedure manuals, summaries of patient/client satisfaction surveys, etc.) be collected and placed in a suitable work area for use in scoring compliance using the Scoring Summary Worksheet. After the scoring summary is completed and a compliance score determined it is recommended that a quality improvement plan be developed to plan for implementing opportunities, determined during the self-assessment, to improve compliance. Improving compliance with the Standards for the Practice of Recreational Therapy will result in greater compliance with JC, CARF and CMS standards. This approach will also result in increased consistency and predictability of achieving valued patient/client outcomes.

The Rating Scale

The rating scale used within this document is an adaptation of a rating scale previously used by the Joint Commission (JC). The initial ATRA Standards of Practice Committee felt that use of a similar scale and terminology would enhance familiarity with the scale and also enhance understanding of the degree of compliance with the ATRA standards of practice. Each of the standards and related structure, process and outcome criteria are to be rated according to the following scale:

- **5 = Substantial Compliance:** Recreational therapy treatment and care consistently meets all major provisions (91-100%) of the standard or criterion.
- **4 = Significant Compliance:** Recreational therapy treatment and care meets most provisions (76%-90%) of the standard or criterion.
- **3 = Partial Compliance:** Recreational therapy treatment and care meets some provisions (51%-75%) of the standard or criterion.
- **2 = Minimal Compliance:** Recreational therapy treatment and care meets few provisions (26%-50%) of the standard or criterion.
- **1 = Non Compliance:** Recreational therapy treatment and care fails to meet provisions (less than 26%) of the standard or criterion.

Space is provided within the document for the rating of each criterion. The ratings of the individual criterion should be averaged to calculate a summary score for the standard. The average rating corresponds to the numerical rating scale. For example, an average rating of 3.6 would indicate slightly better than Partial Compliance, but less than Substantial Compliance with a standard. Similarly a documentation audit score of 87% shows Significant Compliance.
Data sources used in the self-assessment can be identified by circling those listed in the DATA SOURCES or by denoting sources in the EVALUATION COMMENTS section. It is important to identify data sources used in the assessment as a reference for future assessments. Space for comments is provided to illustrate the reasons for the rating and listing recommendations for improvement where possible. A SCORING SUMMARY WORKSHEET is provided in the Self-Assessment Guide to summarize the scores, compute a percentage of the total possible score and document opportunities for improvement.

To avoid the pitfalls of rater bias, it is very important to be objective in a constructive way when rating each criterion. Self-assessment is intended to identify opportunities for improvement in patient/client services and inflated ratings will limit this outcome. Likewise, overly critical ratings may not give credit where it is due. The obvious challenge is to be as accurate as possible. It is important to score the standards/criteria based solely on evidence of actual practice. There should be evidence of the rating chosen, not just an impression that the rating is based upon performance. For example, if an outcome criteria states “The patient/client expresses satisfaction with the outcome of the treatment plan,” documentation should support that the patient/client expressed satisfaction as documented in satisfaction surveys or in the medical record. In this example, documentation of expressed patient/client satisfaction could be the difference between a rating of 5 (Substantial Compliance) and 1 (Non-Compliance). As with most assessment instruments, it is difficult to make the ATRA Self-Assessment Guide and rating scale completely objective. Distinguishing between a rating of 3 (Partial Compliance) and a rating of 4 (Significant Compliance) or between a rating of 3 (Partial Compliance) and a rating of 2 (Minimal Compliance) may prove to be difficult for the rater, particularly when the area being rated is more subjective and less quantifiable. Descriptors (meets some provisions, meets most provisions) are provided for use in these situations. An accurate and constructive judgment is required of the rater. To increase confidence in the rating, practitioners may want to have the self-assessment completed by two raters independently. A comparison of scores and a discussion of variance may be useful to resolve discrepancies, reach a consensus rating and identify opportunities for improvement. As was expressed in the first edition of the standards of practice and is now repeated with decades of experience, the Standards of Practice Committee projects that the consistent use of the Self-Assessment Guide will improve consistency of recreational therapy practice among recreational therapists. It is hoped that consistency of measurement will improve to the point where external program review or an accreditation program review may be possible. Achievement of this goal requires that practitioners use the ATRA Standards for the Practice of Recreational Therapy and Self-Assessment Guide in their agencies to assess compliance with the standards in order to increase the consistency and quality of services delivered.
STANDARDS FOR THE PRACTICE OF RECREATIONAL THERAPY
ASSESSMENT

The recreational therapist receives and responds, consistent with standards, regulatory requirements and policies for the setting, to requests, including referrals and physician orders, for assessment and treatment; and conducts an individualized assessment to collect systematic, comprehensive and accurate data necessary to determine a course of action and subsequent individualized treatment plan. Under the clinical supervision of the recreational therapist, the recreational therapy assistant, commensurate with qualifications, assessed competency and defined clinical supervision, assists the recreational therapist in collecting systematic, comprehensive and accurate data.

Rationale

Recreational therapy is practiced in a variety of health care and human service agencies and must be practiced in compliance with state and federal laws and regulations as well as requirements of regulatory and accrediting agencies that regulate the agencies where recreational therapy is practiced. Standard 1, like all standards, is designed to be universal to recreational therapy practice and is not intended to be specific to service setting or patient/client population. Structure criteria require that policy and procedures define how the standards are applied to a particular setting, in compliance with state and federal laws and regulations, as well as requirements of regulatory and accrediting agencies that regulate the setting where recreational therapy is practiced. Structure criterion 1.1.1. for standard 1 requires that policies and procedures define the process for the recreational therapist to receive and respond to requests, including referrals and physician orders, to initiate recreational therapy assessment and treatment, specific to the setting and the requirements of agencies that regulate it.

In human service agencies a referral or admission to the agency or program may initiate recreational therapy assessment and intervention. In health care agencies involved in the provision of skilled therapies, physician orders are required to initiate recreational therapy provided as active treatment (see glossary for Centers for Medicare and Medicaid Services definition of active treatment).

Physician orders are required by the Centers for Medicare and Medicaid Services (CMS) for skilled therapies providing active treatment, regardless of setting, so this language must be included in this standard and the policy and procedures for recreational therapy provided in settings regulated by CMS. The CMS requirement for physician orders for recreational therapy assessment and active treatment is consistent with standards and guidelines of regulatory agencies and is common practice in health care for initiation of active treatment services. Physician’s orders for active treatment may include orders written by other licensed independent practitioners who are clinically privileged by the organized medical staff and who coordinate and supervise each patient’s treatment, care and services. CMS requires skilled therapies providing active treatment in health care agencies, to have physician orders, supervision and evaluation. Physician orders may not be required by CMS for activities or recreation provided for persons with illnesses or disabling conditions in various settings, but physician orders are recommended for safe and effective recreational therapy practice, even when not required by CMS, for effective clinical supervision and risk management.

Some recreational therapists do not work in settings regulated by CMS so they must define in policy and procedures how requests for recreational therapy are initiated and responded to by the recreational therapist. The language of standard 1 does not restrict or limit recreational therapy practice in any way, in any setting, but does require that the process for receiving and responding to requests for recreational therapy, including referrals and physician orders, are defined in policy and procedures specific to the setting and regulatory requirements of the setting.
Standard 1, in addition to the requirement for receiving and responding to requests, including referrals and physician orders, for recreational therapy assessment and treatment, also requires the recreational therapist to develop a systematic and accurate assessment process which is essential in providing the basis for an individualized, comprehensive treatment plan.
TREATMENT PLANNING
The recreational therapist plans and develops an individualized treatment plan that identifies goals and evidence-based treatment intervention strategies. The recreational therapy assistant, commensurate with qualifications, assessed competency and defined clinical supervision, helps the recreational therapist to plan and develop the individualized treatment plan.

Rationale
The treatment plan is the foundation for the implementation of a successful treatment program and the achievement of desired patient outcomes. It provides for selection of appropriate evidence-based intervention strategies; guidelines for implementation of programs; the basis for patient/client outcome evaluation; discharge planning and possible aftercare. Collaborative planning ensures greater success of achieving desired patient/client outcomes.
PLAN IMPLEMENTATION
The recreational therapist implements an individualized treatment plan, using evidence-based practice, to restore, remediate or rehabilitate functional abilities in order to improve and maintain independence and quality of life as well as to reduce or eliminate activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Implementation of the treatment plan by the recreational therapist is consistent with the overall or interdisciplinary patient/client treatment program. Under the clinical supervision of the recreational therapist, the recreational therapy assistant leads activities and engages patients/clients, individuals and/or groups, to achieve treatment goals and objectives.

Rationale
Recreational therapy treatment and care are an integral part of the interdisciplinary approach in the treatment, habilitation and rehabilitation of individuals within the health care and human services continuum. The recreational therapist uses a patient/client-centered approach to integrate the individualized treatment plan with evidence-based intervention strategies to achieve optimal patient/client outcomes.
RE-ASSESSMENT AND EVALUATION

The recreational therapist systematically re-assesses, evaluates and compares the patient's/client's progress relative to the individualized treatment plan. The treatment plan is revised based upon changes in the interventions, diagnosis and patient/client responses. Under the clinical supervision of the recreational therapist, the recreational therapy assistant assists in the evaluation of the individualized treatment plan.

Rationale

Re-assessment and evaluation are essential elements in the provision of efficient and effective treatment services. The process of evaluation provides for the routine collection of formative and summative data which allow the recreational therapist to monitor the patient's/client's response to treatment and to revise the treatment plan as necessary.
DISCHARGE/TRANSITION PLANNING
The recreational therapist develops a discharge plan in collaboration with the patient/client, family, significant others and treatment team members in order to discharge the patient/client or to continue treatment and aftercare, as needed. Under the clinical supervision of the recreational therapist, the recreational therapy assistant assists in the development of the discharge plan.

Rationale
The discharge plan is a necessary component of the overall treatment process and is addressed from point of initiation of recreational therapy. It provides for the summarization of patient/client treatment, responses and functional outcomes in preparation for the next level of care. The recreational therapist participates in the discharge planning process to ensure the continuation of treatment or transition to aftercare.
PREVENTION, SAFETY PLANNING AND RISK MANAGEMENT
The recreational therapist systematically plans to improve patient/client and staff safety by planning for prevention and reduction of risks in order to prevent injury and reduce potential or actual harm. The recreational therapy assistant, commensurate with qualifications, assessed competency and defined clinical supervision, helps the recreational therapist to improve patient/client safety and to plan to improve safety and risk management.

Rationale
Recreational therapists actively strive to maximize patient/client benefits and minimize potential risks to reduce the potential of actual physical or psychological injury or harm to patients/clients and staff. Recreational therapists adhere to agency safety goals, in order to provide safe and effective care and treatment. Recreational therapists also develop specific plans to improve safety, minimize risks and maximize benefits in providing recreational therapy interventions.
ETHICAL CONDUCT
The recreational therapist and the recreational therapy assistant adhere to the *ATRA Code of Ethics* in providing patient/client treatment and care that are humane and professional.

Rationale
The patients/clients receiving recreational therapy treatment and care deserve to be treated in the most humane and professional manner. Adherence to the *ATRA Code of Ethics* and the *ATRA Patient’s/Client’s Bill of Rights* ensures that this standard will be met.
WRITTEN PLAN OF OPERATION
Recreational therapy treatment and care is governed by a written plan of operation that is based upon the ATRA Standards for the Practice of Recreational Therapy, state and federal laws and regulations, requirements of regulatory and accrediting agencies, payers and employer’s policies and procedures as appropriate.

Rationale
The written plan of operation is essential to ensure that the recreational therapy treatment and care achieves desired goals and patient/client outcomes. The written plan of operation provides guidance for the management of staff practice, quality improvement, resource management and program evaluation/research.
STAFF QUALIFICATIONS AND COMPETENCY ASSESSMENT

Recreational therapy staff meet the defined qualifications, demonstrate competency, maintain appropriate credentials and have opportunities for competency development.

Rationale

Competencies for recreational therapy practice should evolve and change in response to the dynamic health care environment and effective evidence-based practice. In order to provide quality treatment and care to patients/clients, all recreational therapy staff must meet and maintain minimum professional qualifications for practice. Recreational therapy staff must also demonstrate competency, including competency and qualifications in using modalities and facilitation techniques for treatment interventions and continually enhance their competencies to ensure safe and effective professional practice.
QUALITY IMPROVEMENT
There exist objective and systematic processes for continuously improving patient/client safety and for identifying opportunities to improve recreational therapy treatment and care and patient/client outcomes.

Rationale
Quality improvement mechanisms are employed on a systematic and routine basis, as an aspect of ethical practice, to continually improve patient/client safety and the quality of treatment, care and patient/client outcomes.
RESOURCE MANAGEMENT
Recreational therapy treatment and care are provided in an effective and efficient manner that reflects the reasonable and appropriate use of resources.

Rationale
In an effort to be fiscally accountable, it is necessary to provide quality patient/client treatment and care in the most appropriate and efficient manner. Finite resources must be used in ways that maximize effective patient/client treatment.
PROGRAM EVALUATION AND RESEARCH
Recreational therapy staff engages in routine, systematic program evaluation and research for the purpose of determining the appropriateness and effectiveness of recreational therapy treatment and care provided.

Rationale
Dynamic changes have occurred in health care and human services agencies, and recreational therapy practice continues to evolve. The recreational therapy staff has significant professional responsibility to routinely evaluate and conduct research to maintain an evidence-based practice and to demonstrate that valued patient/client outcomes are achieved on a predictable and consistent basis. The patient/client should receive more effective and efficient treatment as a result of systematic evaluation and research.