Table 2 **Conformity to generic care standards as reported by health care providers and found in the review of the health care records of the children with cerebral palsy**

Standards of care	Reported as usually done (n = 15) No. (%)	Recorded in the child's health file (n = 84) No. (%)
Care assessment standards		
History is taken on personal, family and social circumstances	7 (47)	24 (29)
Developmental history is taken	12 (80)	53 (63)
History of current and past interventions (including outcomes, adverse reactions, side-effects) is taken	11 (73)	16 (19.0)
A consent form is signed by parents/caregiver for care and treatment	1 (7)	0 (0)
The needs of the child and parents/caregivers are recorded	7 (47)	9 (11)
Additional vulnerabilities and co-morbidities are assessed and recorded	10 (67)	72 (86)
Educational, vocational status is recorded	4 (27)	7 (8)
Time for completion of holistic assessment is recorded	6 (40)	12 (14)
Schedule of routine visits is recorded	11 (73)	84 (100)
The diagnosis of cerebral palsy and other diagnoses is recorded	8 (53)	82 (98)
Information on how the diagnosis of cerebral palsy was reached is recorded	5 (33)	18 (21)
Diagnosis of cerebral palsy is explained to the parents	5 (33)	2 (2)
Appropriate information about cerebral palsy is given to the parents in writing	4 (27)	0 (0)
There is cooperation with other partner agencies	0	0
The care plan of the child is structured	7 (47)	8 (10)
Information and guidance (including educational, social and lifestyle advice) are provided to the parents	0 (0)	17 (20)
Care planning standards		
Appropriate advice is provided to parents about available voluntary organizations and advocacy services	1 (7)	9 (11)
The child care plan is planned and agreed with parents/care givers	8 (53)	18 (21)
The timings of review	10 (67)	37 (44)
The other agencies are involved in child's care and support and information is shared with them	1 (7)	6 (7)
The child care plan is based on multidisciplinary assessment of strengths of the rehabilitation process, needs and past experiences	5 (33)	11 (13)
The care plan of the child is clear	0 (0)	49 (59)
The child care plan identifies the specific goals of the child in relation to his/her condition	5 (33)	82 (98)
The child's tasks, treatments and interventions are identified in the care plan of the child	0 (0)	50 (60)
Care delivery standards		
When to initiate, review or end medication and recording of their side-effects	10 (67)	2 (2)
Reasons for inpatient admission are recorded	5 (33)	2 (2)
Aims of admission are recorded	2 (13)	0 (0)
Expected and actual length of inpatient stay are recorded	1 (7)	0 (0)
Plan for discharge is recorded	1 (7)	29 (34)
Outcome standards		
What has improved in the child's condition is recorded	7 (46)	28 (33)
What has become worse in the child's condition is recorded	7 (47)	1 (1)
Achievement of the planned outcomes is recorded	0 (0)	17 (20)
Aspects of the plan that have been changed are recorded	7 (47)	6 (7)