British Society of Rehabilitation Medicine
Promoting quality through education and standards

Rehabilitation for patients in the acute care pathway following severe disabling illness or injury: BSRM core standards for specialist rehabilitation

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This document was prepared by a Working Party of the British Society of Rehabilitation Medicine.

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Introduction

After severe disabling illness or injury many patients will need input from rehabilitation services including from rehabilitation consultants. Often the input may be limited to assessment, giving advice and setting expectations, and possibly organising relatively simple interventions. A significant number of patients will have more complex needs requiring more prolonged involvement from a multi-disciplinary team with expertise in rehabilitation - and a smaller number will have highly complex needs and will require specialist rehabilitation. The majority of these will have some level of neurological impairment, but some will have more general impairments.

Specialist rehabilitation is a critical component of the acute care pathway, without which networks for trauma, stroke, neurosciences etc will inevitably fail and patient outcomes will be compromised. This document outlines the identification of patients with complex rehabilitation needs and sets out core standards to define the role of specialist rehabilitation, and in particular the role of Consultants in Rehabilitation Medicine (RM) and their teams, within the Adult Acute Care Pathway (16 years and over). The standards are limited to adults because children are outside the expertise of this working group. However, many of the principles will also be applicable for patients under the age of 16 years.

In 2012, the BSRM published core standards for specialist rehabilitation within the major trauma pathways, including implementation of the specialist rehabilitation prescription (http://www.bsrm.co.uk/Publications.html#BSRMstandards). It has since been highlighted in many quarters that what works for major trauma is equally applicable for patients managed in acute care pathways following any severe disabling illness or injury, including but not limited to:

- Acquired brain or spinal cord injury
- Stroke
- Guillain Barre Syndrome and other polyneuropathies
- Other complex conditions requiring prolonged hospitalisation or management on a critical care unit (intensive and high dependency units).

This document sits alongside the BSRM Core standards for Specialist Rehabilitation following Major Trauma, and applies the same principles of assessment of rehabilitation need for patients who have disabling illness or injury but are not on a trauma pathway.

Part 1: Background

What is severe disabling illness or injury?

By its very nature, severe disabling illness or injury can result in a complex range of impairments and disabilities, producing a mixture of physical, cognitive, emotional, social and behavioural difficulties.

In this context, severe illness or injury can be defined as a condition that may require a prolonged period of hospitalisation, and results in physical, cognitive or psychosocial disability (or a combination of these) that requires specialist rehabilitation in order to achieve successful re-integration back into the community.

What is specialist rehabilitation?

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living[1].

Specialist rehabilitation is the total active care of patients with complex disabilities by a multi-professional team who have undergone recognised specialist training in rehabilitation, led /supported by a consultant trained and accredited in rehabilitation medicine (RM)[1].

Evidence: There is now a substantial body of trial-based evidence and other research to support both the effectiveness and cost-effectiveness of specialist rehabilitation[2-7]. Despite their longer length of stay, the cost of providing early specialist rehabilitation for patients with complex needs is rapidly offset by longer-term savings in the cost of community care, making this a highly cost-efficient intervention[8, 9].

In the context of acute care, the core activities of a **Consultant in RM** include[10]:

- Diagnosis and medical management of conditions causing complex disability from a rehabilitation perspective. These include any newly acquired neurological, musculoskeletal or other impairment. Also any pre-existing physical, psychological or mental health conditions and their combined impact on disability and participation.
- Anticipation and prevention of physical, psychological and social complications, based on knowledge of a condition's natural history and prognosis
- Evaluation of potential to gain from rehabilitation and prognosis for recovery.
- Informing the acute medical and therapy teams about probable function outcomes.
- Defining rehabilitation needs and directing patients to appropriate rehabilitation services
- Coordinating care and collaborating with other medical and therapy teams
- Communicating with families to provide information, support them in distress and manage expectations.
- Provision of rehabilitation follow-up after discharge and involvement in ongoing community-based rehabilitation.

RM Consultants therefore play a vital role in post-acute care, and should be closely involved **both at a clinical level and in the planning and delivery** of services across all components of the acute care pathway. They are particularly involved with the planning of specialist services for patients with complex needs, but also provide a networking role to support local non-specialist services. RM Consultants have knowledge of the local service options available and play a critical role in signposting patients towards the services that are best able to meet the individual's rehabilitation needs at any given time, facilitating timely progress along the rehabilitation pathway by expediting referrals etc. They also provide an important resource for advice and training of staff within acute care settings with respect to rehabilitation needs and interventions.

Which patients need specialist rehabilitation?

The majority of patients in the acute care pathway will have an uncomplicated recovery and their rehabilitation needs can be met within their local general (Level 3) rehabilitation services (see Figure 1). However, NHS England's Service specification for Specialised Rehabilitation for patients with Highly Complex needs [11] defined three levels of service (1-3) and four categories of patient

need (A-D). Patients with more complex needs (category A or B) require specialist rehabilitation. Details of these levels and categories may be found on the BSRM website.
http://www.bsrm.co.uk/publications/Levels_of_specialisation_in_rehabilitation_services5.pdf

Category A needs describe very complex needs for rehabilitation requiring the highly specialised skills and facilities of a tertiary (Level1) centre. Patients with category B needs have complex needs, requiring specialist rehabilitation, but these can be met by a local specialist (Level 2) service.
The precise nature of these needs will vary from patent to patient and will dictate the specific nature of the service required, but they fall broadly under six main headings:

- Specialist rehab medical (RM) or neuropsychiatric needs, including management of unstable medical / psychiatric conditions
- Specialist clinical rehabilitation needs (for physical, cognitive or behavioural management of patients and support for their families)
- High intensity
- Specialist Vocational Rehabilitation
- Medico-legal and ethical issues eg complex best interests decision-making
- Specialist facilities / equipment needs.

Within the acute care pathways, all patients with severe disabling illness or injury should be assessed by a consultant in RM or their designated deputy. If their needs for rehabilitation are confirmed as category A or B, a **specialist rehabilitation prescription** should be drawn up by the Consultant or their designated deputy, who will then expedite transfer to an appropriate specialist rehabilitation setting as rapidly as possible. Level 1 and 2 rehabilitation services have different commissioning arrangements from Level 3 services; the specialist rehabilitation prescription will also play an important role in identifying activity, and providing essential data to initiate the appropriate currency and tariff.

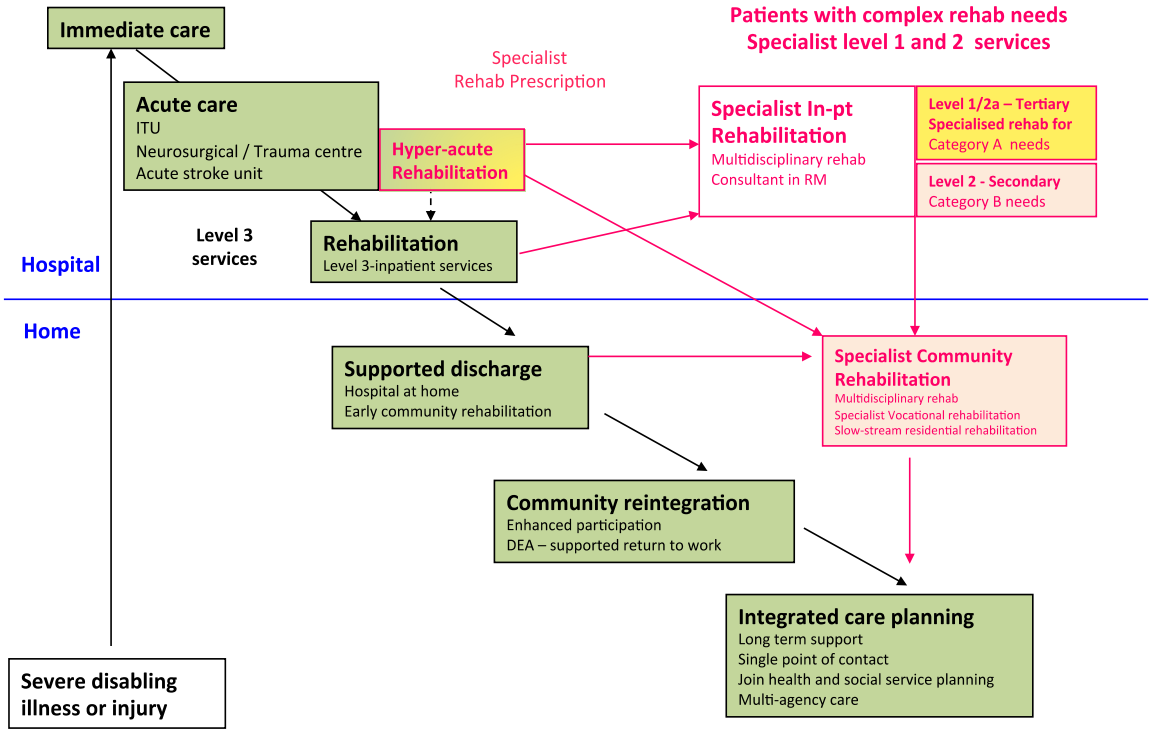
Within stroke pathways, it is recognised that many patients may have multiple co-morbidities that are best managed in Care of the Elderly settings. Nevertheless, a small but significant number of stroke patients, especially those of working age, require specialist rehabilitation to maximise their opportunities for return to independence and previous extended roles such as work, parenting etc. Those who have sustained posterior fossa stroke, requiring tracheostomy, often require specialist rehabilitation in order to optimise the potential for tracheostomy decannulation, and thus maximise the possibility of return home.

Commissioning pathways

For the majority of patients (category C or D needs) rehabilitation is provided and commissioned through the local general (Level 3) rehabilitation services (ie the green pathway in Figure 1).

- Patients with more complex rehabilitation needs (category B) will require specialist rehabilitation (yellow pathway) from their local Level 2 services, which are further divided into Level 2a (supra-district) and 2b (local) specialist services.
- A small number with very complex (category A) needs will require rehabilitation in a tertiary (Level 1) service - or in a level 2a service with enhanced capacity to support patients with highly complex needs.

Figure 1: Pathway for patients with severe disabling illness or injury



Under the commissioning arrangements starting in April 2013, mandated commissioning currencies for inpatient specialist rehabilitation (Level 1 and 2 services) are implemented through the national commissioning database for specialist rehabilitation, held by UK Rehabilitation Outcomes Collaborative (UKROC).

- Patients with category A needs in level 1 and some designated level 2a services are directly commissioned by NHS England.
- The remainder of specialist rehabilitation services are commissioned by the Clinical Commissioning Groups (CCGs).

Therefore an important role of the rehabilitation prescription is to signpost patients down the appropriate pathway and to collect essential data for commissioning.

For patients assessed as requiring specialist rehabilitation following severe disabling illness or injury, the key data items collected at discharge from acute care unit should be as described in the Specialist Rehabilitation Prescription and must be aligned to the UKROC dataset.

These standards lay down a process for identification of patients with complex rehabilitation needs, compilation of their specialist rehabilitation prescription and referral to specialist rehabilitation.

Service models for specialist rehabilitation – Hyper-acute rehabilitation

Early mobilisation is shown to enhance recovery and improve functional outcomes for patients in acute and intensive care settings[12]. Service models for specialist rehabilitation provision within the acute care pathways will vary according to local policy, geography and existing service provision. A number of different service models are described in other BSRM documents[1] [10]. They include:

- Hyper-acute rehabilitation units
- Designated level 1 and 2 specialist rehabilitation units within acute care settings
- In-reach and outreach services from the Level 1/2 units to support rehabilitation for patients undergoing treatment in critical and acute care services.

Hyper-acute rehabilitation refers to the very early stage of rehabilitation for patients who have been stepped down from critical care or high dependency units and still have unstable medical needs. They may no longer need to be under the direct care of acute medical and surgical teams etc, but still require these specialties to be immediately available for advice or management of complications. In the past such patients have been 'repatriated' into non-specialist, non-rehabilitation beds, often in a different hospital. This is inappropriate because neither their needs for rehabilitation or for specialist acute care can be met.

There are several possible models of provision of very early specialist rehabilitation within the acute care pathway:

1. **A dedicated acute rehabilitation unit, led by a Consultant in RM, and with a dedicated multi-disciplinary rehabilitation team is located in, or very close to the acute care unit.**

   The benefits of this model are:

   a) Patients with severe disabling illness/injury and complex rehabilitation needs remain in or near to the acute care unit where relevant medical/surgical expertise is readily available.
   b) Their care is provided by a dedicated acute rehabilitation team of nursing, and therapy staff under the medical leadership of the consultant in RM, within a setting that provides a 24-hour rehabilitation approach, and a peer group of other patients undergoing a similar programme (ie 'a rehabilitation milieu')
   c) Robust governance systems can readily be put in place and the team can develop expertise in this complex area of care.
   d) Drawbacks are the requirement for space within the acute care setting.

2. **Dedicated rehabilitation beds within the acute ward, with rehabilitation patients being under the care of a RM consultant, sharing nurses and AHPs with acute specialities**

   This model also provides proximity to the relevant medical/surgical expertise. Disadvantages, however, are that it may be more difficult to provide a rehabilitative milieu and to determine when the treatment spell changes from acute care to rehabilitation. If rehabilitation is not the sole purpose for admission the treatment may not attract the rehabilitation tariff.

   It is clearly not feasible or practical to provide hyper-acute rehabilitation beds in every acute care setting. Therefore, it is essential that consultants in RM work closely with their acute care colleagues through in-reach and out-reach services, and that these are commissioned appropriately.

Audit of acute care and specialist rehabilitation

The scheme (shown in Appendix 1) is a framework for implementation of the specialist rehabilitation assessment / prescription pathway.

It is accepted that some elements of this are aspirational at present, due to limited capacity, but the inpatient elements of data collection are supported within the UKROC and in use in the majority of specialist (Level 1 and 2) services in England.

Competencies, specialist skills for RM consultants

In order to meet the standards laid out in this document, a pool of appropriately skilled consultants in Rehabilitation Medicine will be required. The current curriculum for specialist training in Rehabilitation Medicine does not adequately address the specific competencies required for acute care rehabilitation – especially in the hyper-acute trauma rehabilitation services. As part of the development of the BSRM Core Specialist Rehabilitation following Major Trauma, the development group drew up a list of core skills for consultants specialising in this area (http://www.bsrm.co.uk/Publications.html#BSRMstandards).

Many of these skills and competencies are similarly applicable in other parts of the acute care pathway and so will not be repeated here. However we have listed out some key areas in which consultants either need to acquire skills themselves - or ensure that they have access to within their immediate clinical support teams (see Appendix 4).

Depending on their background training in general medicine/surgery, trainees may require an additional clinical fellowship year working at the interface between acute care and rehabilitation services to hone their skills and confidence in this exciting but demanding area of clinical practice.

Part 2: Rehabilitation Prescription in the acute care pathway:

The BSRM Core Standards for Specialist Rehabilitation following Major Trauma set out a process for implementation of the Rehabilitation Prescription within the major trauma networks.

The same principles are equally applicable in other acute care services:

- The **Rehabilitation Prescription (RP)** may be used to document the rehabilitation needs of patients with severe illness/ injury and identify how they will be addressed.
- The RP should be initiated at an early stage - usually within 2-3 days of admission to the acute care service.
- It may be started by any suitably qualified member of staff, including a Band 7 Allied Health professional (AHP) or therapist, but is completed by the multidisciplinary team.
- It should be reviewed at regular intervals (at least weekly) until discharge or transfer to rehabilitation, when the RP is replaced by rehabilitation processes (goal setting, multi-disciplinary reviews etc).

The RP encompasses several different components, including:

- A description of the injuries/illness, relevant psycho-social background, risks and treatment to date
- An individualised (text-based) description of rehabilitation needs / recommendations in sufficient detail to inform planning and delivery of on-going rehabilitation / care.
- Essential data collection using standardised data collection tools for audit and commissioning.

Category C or D rehabilitation needs can usually be addressed through a standard RP and managed in the level 3 services. However, the standards in this document focus on patients with more complex needs who require specialist rehabilitation.

Specialist Rehabilitation Prescription for Patients with more complex needs:

Patients with more complex needs are likely to require a longer period of treatment in the acute care service, and may also have complex needs for rehabilitation, requiring referral into the specialist (level 1 or 2) rehabilitation pathway.

- Entry to this Level 1 / 2 pathway requires generation of a **Specialist Rehabilitation Prescription (SpRP)** made by a Consultant in Rehabilitation Medicine (or their designated deputy), as noted above.
- The SpRP is a process for identifying patients who have complex rehabilitation needs, confirming those needs, and sign-posting the patient appropriately for rehabilitation and/or ongoing care.
    - Patients thought likely to have category A or B needs can be identified by the acute care team using the checklist in Appendix 2 to determine which patients to refer for specialist rehabilitation assessment.
    - The consultant in RM or their deputy then completes the SpRP to confirm the category of need, and expedite referral to the appropriate level of service.

The SpRP includes key data items that are reported to UKROC:

- The Rehabilitation Complexity Extended Trauma version (RCS-ET) adapted for other acute care settings (see Appendix 2 for details)
- The full Patient Categorisation Tool (PCAT) to confirm category A or B needs

- The Northwick Park nursing Dependency Scale (NPDS) (which also translates to a Barthel Index)
- The Neurological/Trauma Impairment Set.

Copies of these tools are available electronically through the UKROC website
http://www.csi.kcl.ac.uk/ukroc

The first SpRP is usually finalised at the point of discharge from an acute care unit. However this is a living document, which will follow the patient and change over time in accordance with their changing needs.

- Where feasible it should be held by the patient
- It should be regularly updated – especially at all transfers of care
- It includes referrals to many agencies other than health
- It may be used to audit whether people receive services that they are referred to, in terms of both quality and quantity.

Delayed transfer to rehabilitation is a significant problem for the acute care pathway, extending length of stay in a clinically inappropriate environment for the patient. The reasons may include lengthy waiting lists for rehabilitation services or genuine medical/surgical instability preventing transfer to post-acute rehabilitation. Some patients may fluctuate over time between instability and fitness for rehabilitation; provision of specialist hyper-acute rehabilitation beds would enable transfer of patients, who still need care in an acute environment, into a rehabilitation setting.

The RCS-ET was developed as an extension of the RCS-E to assist in monitoring of delayed transfers within the trauma network, for audit purposes. The only structural difference between the RCS-ET and the RCS-E v13 is the addition of two levels within the RCS-M score to denote medical acuity while the patient is still in the MTC.

Once again the same principles apply in other acute and critical care settings, so the RCS-ET has been adapted for these services

- The ‘R point’ is the point in the pathway when the patient is ready to transfer from the acute care setting to a rehabilitation ward/to the care of the rehabilitation team. This clinical decision is usually made by the acute care team on the daily ward round.
- Daily recording of the RCS-ET M-scores, may be used to inform definition of the R-Point and monitor continued fitness for transfer
    - At M = 6, the patient still requires care in the critical care setting
    - At M = 5, they require ongoing acute care but this can be delivered in an acute care ward, which may be in a local emergency hospital or specialist service eg: medical, surgical, neurological etc
    - At M = 4, they still have acute medical / surgical needs requiring out of hours care in an acute care setting, or hyper-acute rehabilitation unit where this is available.

At M1-3 they are ready for transfer to a rehabilitation service with the following levels of medical care:

- M = 3 - access to 24-hour emergency cover for potentially unstable problems
- M = 2 - specialist investigations or procedures
- M = 1 - routine medical monitoring/ surveillance

At M = 0 their medical/surgical trauma needs could be met at home.

When an adequate hyper-acute rehabilitation service is available, patients may be considered to have reached the R-point when the M score is consistently 4 or below, as ratified by the consultant in Rehabilitation Medicine or their designated deputy.

After patients have been transferred to specialist rehabilitation, the standard outcome assessment tools in the UKROC dataset are recorded at the required intervals for specialist rehabilitation services. The FIM+FAM and associated Impairment Set are recorded at admission and discharge, and thus contribute to the longer-term evaluation of outcome from the acute care pathways.

BSRM Core standards for Specialist Rehabilitation following in the Acute Care pathway

1. BSRM standards for specialist rehabilitation within the Acute Care pathway:	
1.1	RM Consultants should be closely involved both at a clinical level and in the planning and delivery of all Major acute care pathways (including critical care, neurosciences and stroke) to support and direct rehabilitation for patients with complex needs. • Within each network an identified RM Consultant (or consultants) should be an integral part of the acute care pathway team.
1.2	The above roles will normally involve a consultant in RM attending the acute care unit at least once week, which should be written into their job plan. • This role should be shared by 2 or more consultants to provide cover for leave etc
1.3	The RM consultant should be involved from an early stage in the patient's acute care pathway to: • assess patients with complex rehabilitation needs • participate in the planning and execution of their interim care and rehabilitation • expedite referral and transfer for on-going rehabilitation as soon as they are fit enough.
1.4	At an operational level, key roles for the consultant should include: • Overseeing the triage and identification of patients with complex rehabilitation needs, including training of MTC staff in the use of assessment tools. • Multidisciplinary wards rounds and team-based planning meetings • Specific clinical interventions (eg spasticity management, behavioural management plans, assessing patients with prolonged disorders of consciousness etc) • Prognostication – advising the team, patient and family about likely functional outcomes • Case conferences and negotiation with third parties, including commissioners and rehabilitation service providers • Providing information and support for patients' families including on return to work and driving. • Providing rehabilitation follow-up after discharge and support for ongoing community-based rehabilitation.
2. Specialist Rehabilitation Prescription:	
2.1	Patients who have (or are likely to have) on-going complex physical, cognitive, communicative or psychosocial disability (category A or B needs) should be assessed by an RM Consultant (or their designated deputy) prior to discharge from the acute unit. (The designated deputy can be an individual who has specialist knowledge and training in rehabilitation to a consultant level, eg AHP Consultant in Rehabilitation who works within the specialist rehabilitation team and is authorised by the RM Consultant to sign off a specialist RP on their behalf) (The PCAT Checklist has been developed to help acute care teams identify those patients likely

	to have category A or B needs and so refer them appropriately for specialist review – Appendix 2)
2.2	The RM Consultant (or their designated deputy) should complete a Specialist Rehabilitation Prescription (SRP) at discharge from the acute unit.
2.3	The Specialist RP for patients with complex rehabilitation needs should provide • a comprehensive record of the patient's injuries, psychosocial background, risks and treatment to date • a statement of their rehabilitation needs / recommendations in sufficient detail to inform planning and delivery of on-going rehabilitation / care. (Individual services will develop their own paperwork, but the SRP should include all the headings included in the proforma which is provided as an exemplar for local adaptation [see Appendix 3]).
2.4	The Specialist RP for patients with complex rehabilitation needs should include as minimum the following data which should be entered into the UKROC database: • The Rehabilitation Complexity Extended Trauma version (RCS-ET) adapted for other acute care settings • The full Patient Categorisation Tool (PCAT) to confirm category A or B needs • The Northwick Park nursing Dependency Scale (NPDS) • The Neurological/Trauma Impairment Set
2.5	As for the standard Rehabilitation Prescription, the specialist RP should travel with the patient and should be reviewed and updated at appropriate intervals (at least every 4-6 weeks), to record actions undertaken to implement the recommendations

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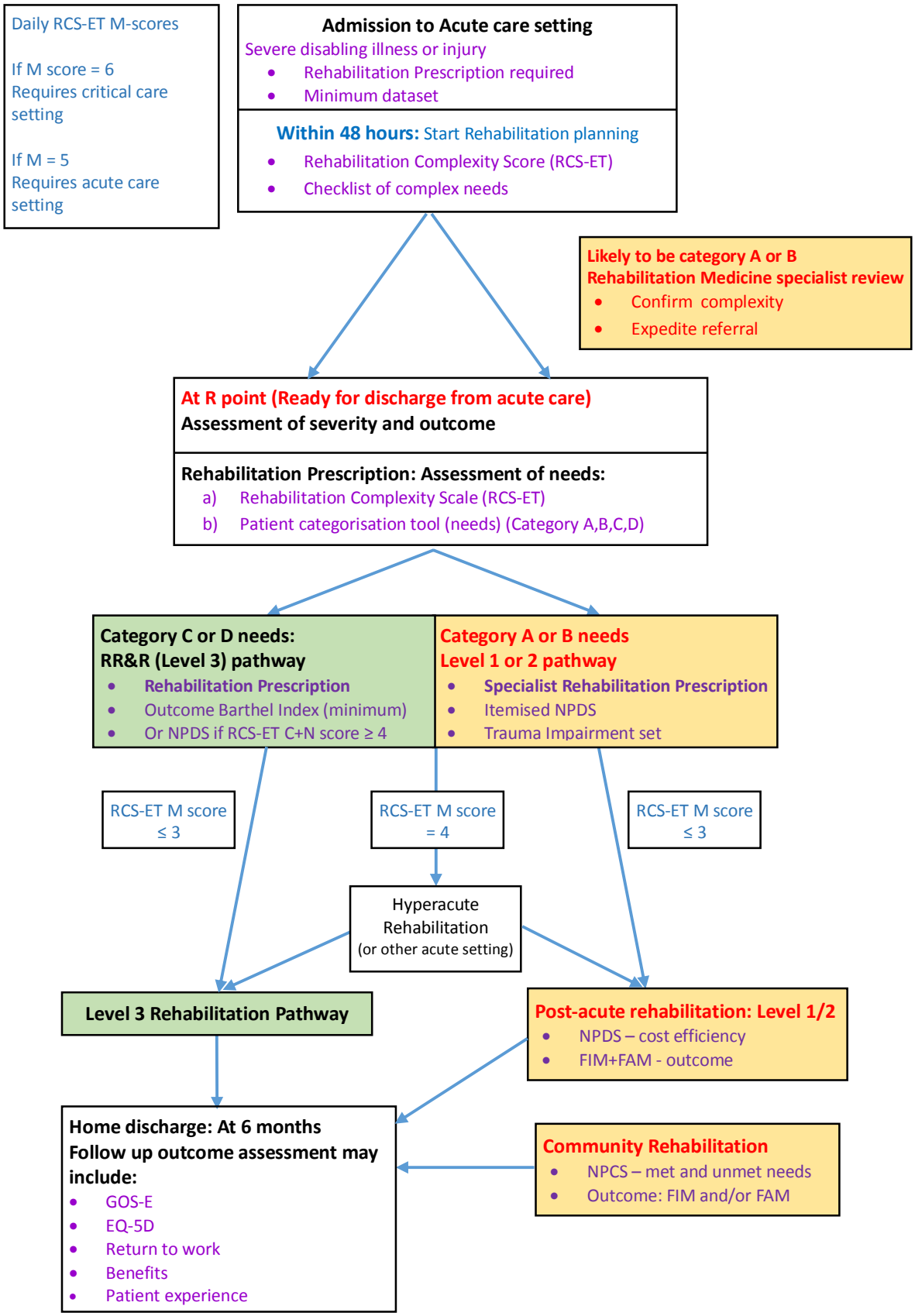
Appendix 1:

Scheme for rehabilitation prescription, pathways and outcome measurement



Appendix 2: Screening checklist for patient categorisation – all Levels (Required elements in red)

Pt Name:	NHS Number	DOB:	ISS:

TARN Minimum dataset	On-going Acute Care requirements:	
Rehabilitation Prescription ❒ Required ❒ Not required **Presence factors affecting activities/participation** ❒ Physical ❒ Cognitive / mood ❒ Psycho-social	❒ Orthopaedic / trauma ❒ Neurology / neurosurgery ❒ Vascular ❒ Abdominal ❒ Cardiothoracic/cardiology ❒ Respiratory medicine ❒ Urology	❒ Plastics ❒ Burns ❒ ENT ❒ Max-fax ❒ Other……

Does the patient have COMPLEX clinical needs?

Complex Physical eg	**Complex Cognitive / Mood** eg	**Complex Psychosocial** eg
❒ Complex musculoskeletal management ❒ Complex neuro-rehabilitation ❒ Complex amputee rehabilitation needs ❒ Re-conditioning / cardiopulmonary rehab ❒ Complex pain rehabilitation ❒ Profound disability / neuropalliative rehabilitation	❒ Complex communication support ❒ Cognitive assessment/management ❒ Complex mood evaluation / support ❒ Challenging Behaviour management ❒ Evaluation of Low Awareness state	❒ Complex discharge planning eg ○ Housing / placement issues ○ Major financial issues ○ Uncertain immigration status ❒ Major family distress / support ❒ Emotional load on staff

Checklist of needs that are likely to require specialist rehabilitation (tick any that apply) (Examples)		**Specialist needs?**
Specialist rehab medical (RM) or neuropsychiatric needs	❒ On-going specialist investigation/ intervention ❒ Complex / unstable medical/surgical condition ❒ Complex psychiatric needs ❒ Risk management or Treatment under section of the MHA	❒ Yes ❒ No
Specialist rehabilitation environment	❒ Co-ordinated inter-disciplinary input ❒ Structured 24 hour rehabilitation environment ❒ Highly specialist therapy /rehab nursing skills	❒ Yes ❒ No
High intensity	❒ 1:1 supervision ❒ ≥4 therapy disciplines required ❒ High intensive programme (>20 hours per week) ❒ Length of of rehabilitation ≥ 3 months	❒ Yes ❒ No
Specialist Vocational Rehab	❒ Specialist vocational assessment ❒ Multi-agency vocational support (for return to work /re-training /work withdrawal) ❒ Complex support for other roles (eg single parenting)	❒ Yes ❒ No
Medico-legal issues	❒ Complex mental capacity / consent issues ❒ Complex Best interests decisions ❒ DoLs / PoVA applications ❒ Litigation issues	❒ Yes ❒ No
Specialist facilities / equipment needs	❒ Customised / bespoke personal equipment needs (eg Electronic assistance technology, communication aid, customised seating, bespoke prosthetics/orthotics) ❒ Specialist rehabilitation facilities (eg treadmill training, computers, FES, Hydrotherapy etc)	❒ Yes ❒ No

Provisional Categorisation of Rehabilitation Needs	
❒ **Category A** (requiring Level 1 or 2a Rehabilitation) ❒ **Category B** (requiring Level 2 Rehabilitation) ❒ **Category C or D** (requiring RR&R pathway)	**If probable category A or B needs,** refer for specialist rehabilitation review: **Referred** Yes / No Date……./……./…….. **Reviewed** Yes / No Date……./……./……..

Rehabilitation Complexity Score (RCS-ET - adapted)						
Care / Risk	**Nursing**	**Medical**	**Therapy-Disciplines**	**Therapy-Intensity**	**Equipment**	**Total Score (0-25)**
0 1 2 3 4 / 0 1 2 3 4	0 1 2 3 4	0 1 2 3 4 5 6	0 1 2 3 4	0 1 2 3 4	0 1 2 3	**……../25**

Assessor (Print Name)	Signed:	Date:

The Rehabilitation Complexity Scale – (RCS ET - Acute care)

PATIENT IDENTIFICATION

Name: **Hospital No:** **Date of score:...../...../.....**

For each subscale, circle highest level applicable

MEDICAL NEEDS

Describes the approximate level of medical environment required for medical/surgical/trauma management

M 0	**No active medical intervention** (Could be managed by GP on basis of occasional visits)	**Tick medical/surgical interventions required:**
M 1	**Basic investigation / monitoring / treatment** (Requiring non-acute hospital care, could be delivered in a community hospital with day time medical cover)	❒ Specialist investigations – blood tests, imaging etc ❒ On-site co-ordinated specialist opinion / intervention ❒ Access to specialist medical equipment for assessment /monitoring etc
M 2	**Specialist medical / psychiatric intervention – for diagnosis or management/procedures** (Requiring in-patient hospital care in (DGH or specialist)	
M 3	**Potentially unstable medical /psychiatric condition** (Requiring 24 hr availability of on-site acute medical / psychiatric cover)	Type of medical intervention required: ❒ Medical ❒ Surgical ❒ Trauma ❒ Psychiatric ❒ Other.....
M 4	**Acute medical / surgical problem** (Requiring emergency medical / surgical out of hours care - but can be managed in an acute DGH setting, or in a hyper-acute rehabilitation setting)	
M 5	**Acute care needs – primary needs are medical/surgical** (Requiring **coordinated specialist care** in an acute care setting)	❒ Orthopaedic / trauma ❒ Neurology neurosurgery ❒ Vascular ❒ Abdominal / Cardiothoracic ❒ Cardiopulmonary ❒ Plastics/ burns ❒ Urology ❒ Rehabilitation Medicine ❒ Other.....
M 6	**Critical care** (Requiring management in intensive care setting)	

BASIC CARE AND SUPPORT NEEDS

Describes the approximate level of intervention required for basic self-care or level of risk

(For all centres: score both care and risk and use highest score)

	CARE: Standard rehab needs		**RISK: Cognitive behavioural needs**
C 0	Largely **independent** in basic care activities	**R 0**	**No risk**
C 1	Requires **help from 1 person** for most basic care needs	**R 1**	**Low risk –** standard observations only But **requires escorting** outside the unit
C 2	Requires **help from 2 people** for most basic care needs	**R 2**	**Medium risk – above** standard observations OR **managed under MHA section**
C 3	Requires **help from ≥3 people** for basic care needs	**R 3**	**High risk – above** standard observations AND **managed under MHA section**
C 4	Requires constant **1:1 supervision** **–** for safety or behavioural management	**R 4**	**Very high risk** Requires **constant 1:1 supervision**

SKILLED NURSING NEEDS

Describes the level of intervention required from qualified or skilled rehab nursing staff

N 0	No needs for skilled nursing	**Tick nursing disciplines required:**
N 1	Requires intervention from a **qualified nurse** (e.g. for monitoring, medication, dressings etc)	❒ General registered nursing ❒ ITU nurse ❒ Specialist trauma nurse (eg orthopaedic, amputee etc) ❒ Rehab-trained nurses ❒ Mental Health (RMN) ❒ Other..... ❒
N 2	Requires intervention from **trained rehabilitation nursing staff** and/or **mental health nurses**	
N 3	Requires **specialist nursing care** (e.g. for tracheostomy, behavioural management etc)	
N 4	Requires **high dependency specialist nursing** (eg medically unstable, very frequent monitoring/ intervention by a qualified nurse - hourly or more often)	

THERAPY NEEDS
Describes the approximate level of input that is required from therapy disciplines

Therapy Disciplines: State **number of different therapy disciplines** required to be actively involved in treatment

TD 0	**0**	**Tick therapy disciplines required:**		
TD 1	**1** disciplines only	❒ Physio ❒ O/T ❒ SLT ❒ Dietetics ❒ Social work	❒ Psychology ❒ Counselling ❒ Orthotics ❒ Prosthetics ❒ Rehab Engineer	❒ Music/art therapy ❒ Play therapy/school ❒ DEA/Jobcentre Plus ❒ Recreational therapy ❒ Other :
TD 2	**2-3** disciplines			
TD 3	**4-5** disciplines			
TD 4	**≥6** disciplines			

Therapy Intensity: State **overall intensity of trained therapy intervention** required from team as a whole

TI 0	**No therapy intervention** (or<1 hour total/week - Rehab needs met by nursing/care staff or self-exercise programme)
TI 1	Low level – **less than daily** (eg assessment / review / maintenance / supervision) OR **Group therapy only**
TI 2	Moderate – **daily intervention - individual sessions with one person** to treat for most sessions OR **very intensive Group programme** of ≥6 hours/day
TI 3	High level – **Daily intervention with therapist PLUS assistant and/or additional group sessions**
TI 4	Very High level – **very intensive** (eg 2 trained therapists to treat, or total 1:1 therapy >30 hrs/week)
Total	**Total T score (TD + TI) :.....**

EQUIPMENT NEEDS
Describes the requirements for personal equipment

E 0	**No needs** for special equipment	Basic Special Equipmt	Highly Specialist Equipmt
E 1	Requires **basic special equipment**	❒ Wheelchair/seating ❒ Pressure care ❒ Standing frame ❒ Off-shelf orthotic ❒ Walking aid ❒ Other.....	❒ Environmental control ❒ Communication aid ❒ Customised seating ❒ Customised standing aid ❒ Customised orthotic / brace ❒ Assisted Ventilation ❒ Other.....
E 2	Requires **highly specialist equipment** (eg electronic assistive technology or highly customized equipment)		
E3	Requires **extremely specialist equipment** (ie Really fancy hi-tech trauma equipment only available in MTC!)	**State equipment type:**	

TOTAL SCORE SUMMARY	**Needs scores**	**Totals:**		**Currently gets**	**Reason for unmet need** (eg Not available (NA), declined (D), or Other…)
Medical / Surgical / Trauma / Psychiatric treatment	**M:**	**Medical:**	**/ 6**	**M:**	☐ NA ☐ D ☐ Other..
Basic care and support (Includes risk management)	**C: or R:**	**Care /risk**	**/ 4**	**C: or R:**	☐ NA ☐ D ☐ Other..
Skilled Nursing care	**N:**	**Nursing**	**/ 4**	**N:**	☐ NA ☐ D ☐ Other..
Therapy	**TD:**			**TD:**	☐ NA ☐ D ☐ Other..
	TI:	**Therapy:**	**/ 8**	**TI:**	☐ NA ☐ D ☐ Other..
Specialist equipment	**E:**	**Equipment**	**/ 3**	**E:**	☐ NA ☐ D ☐ Other..
		Summed RCS	**/ 25**	**Gets /25**	

Appendix 3: Specialist Rehabilitation Prescription Proforma (example).

For patients with complex rehabilitation needs requiring Specialist (Level 1 or 2) Rehab services.
The specialist rehabilitation Prescription should be complete/ signed off by a Consultant in Rehabilitation Medicine or their deputy at discharge from the acute care settng.
This proforma is provided as an exemplar for local adaptation. **(Required elements are in red)**

<table>
<tr><td>NHS no:</td><td colspan="2">Date of Injury:</td></tr>
<tr><td>Insert label or:</td><td colspan="2">Type(s) of illness/ injury:</td></tr>
<tr><td>Surname:
First name
Date of birth:
Address:

GP:</td><td>Neurological:
❒ Brain injury
❒ SCI
❒ Peripheral nerve
❒ Musculoskeletal</td><td>Other:
❒ Vascular
❒ Burns
❒ Thoracic
❒ Abdominal
❒ Amputation</td></tr>
<tr><td>Family contact/ Next of kin</td><td colspan="2">Contact phone number for family member</td></tr>
<tr><td>Current location:
MTC:</td><td colspan="2">Consultant:

Keyworker:</td></tr>
<tr><td colspan="3">Pre-injury / illness information</td></tr>
<tr><td>Significant Past History</td><td colspan="2"></td></tr>
<tr><td>Family support</td><td colspan="2"></td></tr>
<tr><td>Housing</td><td colspan="2"></td></tr>
<tr><td>Work</td><td colspan="2"></td></tr>
<tr><td>Leisure</td><td colspan="2"></td></tr>
<tr><td colspan="3">Description of injuries: (and other details such as initial GCS, PTA etc)</td></tr>
<tr><td colspan="3">Progress/ complications</td></tr>
</table>

Current functional status:

Injuries still requiring active management		**GCS: E...../V...../M.... Total...../15** **Motor loss:** Yes / No **Sensory loss:** Yes / No

Summary of Impairments / function at a glance **(This section is optional as the information is included NPDS and Impairment set)**				
Sensory and upper limb	**Vision** ❒ Intact ❒ Impaired ❒ Unassessable	**Hearing** ❒ Intact ❒ Impaired ❒ Unassessable	**Perception** ❒ Intact ❒ Impaired ❒ Unassessable	**Upper limb function** ❒ Intact ❒ Impaired ❒ Non functional
Posture and pressure management	**Sitting out** ❒ Standard chair ❒ Special seating ❒ Unable	**Pressure relief** ❒ Independent ❒ Assisted + 1 ❒ Assisted + 2	**Pressure sores** ❒ Yes ❒ No Location and grade:	**Risk** ❒ Waterlow ❒ Braden Score.....
Mobility	**Transfers** ❒ Independent ❒ Assisted + 1 ❒ Assisted + 2 ❒ Hoisted	**Walking** ❒ Independent ❒ Assisted + 1 ❒ Assisted + 2 ❒ Unable	**Wheelchair** ❒ None required ❒ Independent ❒ Assisted ❒ No chair	**Wandering** ❒ No ❒ Low risk ❒ High risk
Sphincters and Continence	**Bladder control** ❒ Toilet ❒ Commode/urinal ❒ Catheter/convene ❒ Pads	**Bladder Assistance** ❒ Independent ❒ Assisted + 1 ❒ Assisted + 2	**Bowel control** ❒ Toilet ❒ Commode ❒ Pads	**Bowel Assistance** ❒ Independent ❒ Assisted + 1 ❒ Assisted + 2
Nutrition	**Consistency of diet** ❒ Normal diet/fluids ❒ Soft/pureed ❒ NG/PEG feed	**Swallowing** ❒ Normal ❒ Impaired	**Feeding** ❒ Independent ❒ Assisted + 1	**Nutrition** MUST score: .....
Ventilatory	**Oxygen support** ❒ Yes .....% ❒ No	**Tracheostomy** ❒ Yes ❒ No	**Ventilatory support** ❒ Full support ❒ Assisted (CPAP) etc ❒ None	**Details:**
Cognitive / communication	**Communication** ❒ Normal ❒ Impaired ❒ Unable	**Cognitive** ❒ Normal ❒ Impaired ❒ Unconscious	**Behaviour** ❒ Normal ❒ Impaired	**Mood** ❒ Normal ❒ Impaired

Rehabilitation Complexity Scale Extended (RCS-E) Trauma version (as confirmed by Rehab Physician)

	0	1	2	3	4	5	6
Medical	None active	Basic	Specialist	Potentially unstable	Acute needs can be met in hyper-acute rehab setting	Acute care	Critical care
Care	Independent	1 carer	2 carers	≥ 3 carers	1:1 supervision		
Risk	None	Low	Medium	High	Very high		
Nursing	None	Qualified	Rehab nurse	Specialist nursing	High dependency		
Therapy disciplines	None	1	2-3	4-5	≥ 6		
Therapy Intensity (Total therapist time)	None	low level (< daily) <15 hrs/wek	Moderate (eg daily) 15-24 hrs/wk	High (+ assistant) 25-30 hrs/week	Very high >30 hours/week		
Equipment	None	Basic	Specialist	-	-		

RCSE: M..... C..... N..... Td..... Ti..... E..... **Total ...../24**

Detail of Rehabilitation needs

	Optional checklist	Details
Medical	❒ Medical management ❒ Orthopaedic ❒ Neurosurgical ❒ Amputee ❒ Other:	
Physical	❒ Mobility ❒ Upper limb function ❒ Postural support (seating/W/C) ❒ Splinting / orthotics ❒ Spasticity ❒ Pain ❒ Other:	
Basic functions	❒ Tracheostomy / ventilator ❒ Respiratory / pulmonary rehab ❒ Continence – urinary / faecal ❒ Wound management ❒ Swallowing /nutrition ❒ Communication ❒ Other:	
ADL	❒ Personal care / ADL ❒ Continence ❒ Extended ADL ❒ Vocational ❒ Educational ❒ Other:	
Cognitive / psychosocial	❒ Sensory (Vision / hearing) ❒ Cognitive / perceptual ❒ Behavioural management ❒ Mood / emotion ❒ Formal family support ❒ Other:	
Discharge planning	❒ Housing / placement ❒ Benefits/finances ❒ Equipment / home adaptations ❒ Community visits ❒ Emotional load on staff ❒ Other:	
Equipment	❒ Orthotics/Prosthetics: ❒ Mobility aids/transfer equipment ❒ Specialist seating ❒ Bed/posture Management ❒ ADL equipment ❒ Other (eg Environmental controls)	
Any on-going risks		

Summary

Expected duration of admission	Patient category confirmed	Service Level required	Please ensure the following are completed and entered in the UKROC dataset:
❒ Assessment /rapid intervention (2-4 wks) ❒ Short stay (eg 6-8 wks) ❒ Medium stay (eg 3-4 mths) ❒ Long stay (eg 5-6 mths)	❒ A ❒ B ❒ C ❒ D	❒ Level 1 ❒ Level 2a ❒ Level 2b ❒ Level 3 ❒ Other	❒ RCS-ET (as above) ❒ Full Patient Categorisation Tool ❒ Itemised NPDS (for NPCNA) ❒ Impairment set

If not for rehabilitation: Reason and alternative recommendations:

Name and contact details of your key worker:
YOUR REHABILITATION PRESCRIPTION: Services referred to: (including contact details and anticipated waiting time)
Other key information (eg patient/family wishes. potential barriers to discharge)

INFORMATION GIVEN TO PATIENT / FAMILY
About their condition and treatment on the MTC
About their further treatment / follow-up
Other forms of support (eg Headway)
Anything else

Appendix 4: Key skills and Competencies for Consultants in Rehabilitation Medicine working within the Acute Care Pathway

The practice of Specialist Rehabilitation within the acute care pathway has led to increased involvement of Rehabilitation Medicine (RM) Consultants and trainees within acute assessment and step-down rehabilitation units.

Patients are coming under the care of a RM Consultant much sooner at a time when their medical state is less stable and their clinical presentation is still evolving. These developments are welcomed as it should reduce hospital length of stay, prevent adverse events and improve overall outcome. Many Rehabilitation Medicine specialists are already practising in this way but some will need to extend their skills in order to practise in effective inter-specialty teams with their acute colleagues. This will be reflected in a new specialty training curriculum with the introduction of new advanced competencies for those wishing to practise in this area.

Within the Core Standards for Specialist Rehabilitation following Trauma the BSRM recommends a list of skills to senior trainees or RM CCT holders practising in specialist rehabilitation following trauma. Many of these competencies are equally applicable in the context of the Acute Care Pathways, and so will not be repeated in detail here.

It is not expected that all consultants in RM will personally have competencies in all areas. Nevertheless, the list may help consultants to identify the types of skills that need to be available in his area of care - either provided directly by themselves or through joint working with their clinical support teams.

Although the list below is by no means exclusive, key skills and competencies are likely to include:

- Whilst the patient is still in the acute care setting:
    - Ability to prognosticate and inform the patient/family and acute teams about probable functional outcomes.
    - Interaction with decisions that may affect long-term rehabilitation outcomes eg level of amputations, PEG insertion.
    - Familiarity with the Mental Capacity Act and involvement in assessment of mental capacity and best interests decision-making.
    - Ability to discuss and agree with team sedation breaks for early mobilisation and assessment of responsiveness, cognition and communication.
    - Familiarity with assessment of responsiveness and primary care pathways in patients with prolonged disorders of consciousness.

- In the acute/post-acute rehabilitation setting:
    - Management of on-going medical problems eg sepsis, fluid balance, dysautonomia, wound care, anticoagulation / IV filters etc.
    - Management of delirium, agitation and acute confusional states.
    - Familiarity with tracheostomy care, long-term ventilatory support (eg CPAP, NIPPY 3) cough-assist equipment etc.

      (RM Consultants clearly do not replace the need for a formal ventilator support team, but they should at least be familiar with how the equipment fits together and be able to manage an acutely blocked tracheostomy if they manage these patients in their unit).