

Appendix 1: Standards for specialist in-patient and community rehabilitation services

IN-PATIENT REHABILITATION SERVICES

COMMUNITY REHABILITATION SERVICES

1.	SERVICE PROVISION
1.1	Specialist rehabilitation services should be supported by dedicated sessions from a consultant specialist in rehabilitation medicine
1.2	Disabled individuals within any district should have access to all appropriate rehabilitation services which aim to maximise physical, psychological and social well-being, including: <ul style="list-style-type: none"> • Specialist in-patient rehabilitation services • Out-patient and day rehabilitation services, supported by adequate transport systems to ensure reliable attendance • Home-based /domiciliary rehabilitation services should be available for those unable to travel to a rehab centre, or for whom rehabilitation is more appropriately conducted in the context of their normal home environment.
1.3	Co-ordinated service planning should ensure that suitable services are available within a reasonable travelling distance. In rural areas, this may involve the establishment of satellite services or peripatetic teams to reach isolated locations
1.4	Local (district or community) specialist rehabilitation services should have a defined and publicised target population and a catchment area in order to plan provision in relation to caseload. However, there should be enough flexibility to cater for unusual cases.
1.5	Where gaps exist in local service provision, defined systems for referral and funding should be in place to ensure that disabled individuals can gain timely access to services which are not available in their locality.
2.	THE REHABILITATION TEAM
2.1	Rehabilitation should be carried out by a co-ordinated inter- or multi-disciplinary team(s).
2.2	The rehabilitation programme may be provided by a mix of junior and senior staff, but should be directed by experienced qualified practitioners who regularly keep themselves up to date.
2.3	The team should include all the relevant clinical disciplines, including doctors and nurses trained in rehabilitation, skilled paramedical professionals, psychologists social worker etc.
2.4	Staff numbers, qualification and experience should be adequate to meet the caseload.
2.5	In addition to the core clinical team, there should be access to input from other disciplines, such as rehabilitation engineers, orthotists as required.
2.6	All inter-disciplinary team staff should be readily able to seek specialist advice or intervention from other colleagues when required.
2.7	Cross-boundary working is a critical element of rehabilitation. Each service should have an identified system for liaison with social services or a dedicated social worker as part of the team.

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3. REFERRAL AND ASSESSMENT	3. REFERRAL AND ASSESSMENT
3.1 Specialist rehabilitation services should have: a) defined inclusion criteria and b) a written procedure for referral and for assessment, to ensure appropriate referral and avoid unnecessary time wasted waiting for a service which is inappropriate in the first place.	
3.2 Referral will be accepted from an appropriate agency in accordance with the written referral procedure	
3.3 Where relevant, the funding contract is agreed prior to assessment to avoid disappointment.	
3.4 Each service should have a protocol to gather sufficient relevant information to determine whether it is able to meet the rehabilitation needs of the individual concerned – this may or may not involve face-to-face assessment.	
3.5 Following assessment a written summary will be supplied to the referrer, summarising the case and the individual’s rehabilitation needs, with recommendations for management and the intervention plan. This should be copied to the GP and other relevant agencies, including the individual (patient/client) if appropriate	
3.6 If the service is not deemed appropriate to meet the individual’s needs, the reasons for this will be given and recommendations for suitable alternative(s) will be provided.	
3.7 Each service will have systems in place to deal with urgent referrals and to minimise waiting times for the service	
3.8 Prior to admission to an in-patient service, a named person / agency will be identified to assume responsibility for the individual in case of a placement breakdown, self-discharge, or other emergency.	
4. START OF REHABILITATION	4. START OF REHABILITATION
4.1 If there is a waiting list to join the rehabilitation programme, the service provider informs the referrer, the individual and family or carers of the programme’s starting date with sufficient notice to allow adequate preparation. If the start date is delayed, the referrer is kept informed and regular contact is maintained.	
4.2 Information about the service offered is given to the individual and/or family at or before the start of the programme. This should include information about their condition and about other relevant sources of help or information such as societies, self-help groups etc	
4.3 Relevant clinical information, together with any special needs, is reviewed by the staff and any necessary action or provision is implemented prior to arrival of the individual	4.3 An identified team member provides a point of contact at all times.
4.4 There is a documented orientation/induction procedure.	
4.5 The nursing care plan, where applicable, is completed and initiated within 24 hours of the individual’s arrival.	

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5.	ASSESSMENT AND PROGRAMME PLANNING PHASE	5. ASSESSMENT AND PROGRAMME PLANNING PHASE
5.1	The initial phase of any rehabilitation programme should include programme planning. The programme must be based on the results of the physical, cognitive, communication, psychosocial, functional and environmental assessments in accordance with the stated purpose, and tailored to the needs of the individual.	
5.2	Where relevant, admission may include an initial assessment period to establish suitability for further in-patient rehabilitation and goals for admission.	
5.3	Programme planning should include: <ul style="list-style-type: none"> • A clear statement of the aims of the programme, and component elements that will achieve that purpose • Establishment and documentation of an agreed set of goals for the rehabilitation programme. 	
5.4	The individual should be involved as actively as possible in goal-setting. The goals should include long- and short-term goals and should be agreed between the individual, their family/carers and the rehabilitation team.	
5.5	At an early designated stage in admission, a prediction should be made of the expected outcome of the rehabilitation programme and time scale, even though this may subsequently be reviewed.	
5.6	A standard is set for all documentation related to the assessment and planning phase to complete within a designated time course, and regular audit carried out against that standard.	
5.7	Programme planning should include an action plan to prepare for discharge. Discharge planning should begin as soon as possible or at least by the completion of the assessment phase.	5.7 Programme planning should include an action plan to prepare for discharge, if the programme has a finite course
		5.8 The location, the pace of the rehabilitation process should be determined by negotiation with the individual and due emphasis given to their preferences.

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6	THE REHABILITATION PROGRAMME AND COORDINATION OF THE REHABILITATION PROCESS	
6.1	All major decision-making meetings eg assessment, goal planning, case conferences, discharge planning should be undertaken by the multi-disciplinary team, in conjunction with the individual, and their family and carers where appropriate.	
6.2	There should be clearly defined systems for: <ul style="list-style-type: none"> • ensuring co-ordination of effort between the various different disciplines eg multi-disciplinary patient record system • communicating information to individuals and their families 	
6.3	Designated member(s) of the team should be responsible for: <ul style="list-style-type: none"> • overseeing and co-ordinating the individual’s programme (key-worker role) • supporting the individual during their programme, and acting as their “advocate” in team discussion and meetings from which the individual is absent (advocacy role) 	
6.4	Rehabilitation must be a 24-hour process, carried on out-of hours by the nursing rehabilitation team.	6.4 Rehabilitation must be a continuous process. The individual, and their family and carers should be given guidelines for rehabilitation practice at home between formal rehabilitation sessions.
6.5	The environment must enhance and facilitate the rehabilitation programme and should include the relevant facilities.	6.5 The rehabilitation programme should be adapted to the chosen environment. Where relevant, the individual and their family or carers should be offered help and advice about home adaptation to facilitate both rehabilitation and independence.
6.6	All programmes and goals where possible must be reviewed at frequent intervals – ideally not less than fortnightly – and the programmes adjusted accordingly.	6.6 Programmes and goals should be reviewed at agreed intervals and adjusted accordingly.
6.7	Documented case-conferences or reviews should be held for each individual at agreed intervals, involving patients, carers, relevant agencies and the team.	
6.8	All progress must be documented. There should be written standards for documentation, and these should be regularly audited	
6.9	As part of the rehab programme, the team liaises with statutory, voluntary, and charitable organisations to provide adaptive equipment.	
		6.10 There should be a defined procedure for prioritising the provision of specialist equipment that is funded and provided by the community rehab service.

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7	DISCHARGE	7	DISCHARGE
7.1	All in-patient rehabilitation facilities should have a written policy and procedure for discharge. The latter part of a placement should be geared towards the next stage of the provision.	7.1	All rehabilitation facilities should have a written policy and procedure for discharge, although it is recognised that some patients, by the nature of their conditions or disability should be kept on long term review.
Where discharge is intended:			
7.2	Appropriate discharge provision / planning should take account of a) primary care needs b) accommodation c) day time occupation of the individual and their carers and d) continuing specialist involvement		
7.3	Discharge planning should involve • carers, • current and future providers (e.g. Health and social services, therapists, GP), • professionals from the rehab unit, • the individual with his / her advocate if necessary.		
7.4	Individuals discharged from specialist rehabilitation services should have: • access to generic community health care services through primary care teams • clear information about who to contact should further rehabilitation needs arise • clear information about the source of any equipment provided and who to contact for maintenance and repair. • clear information about who to contact with regard to return to work and vocational issues, if appropriate • information about benefits		
7.5	A designated member of staff should be nominated to co-ordinate the discharge process – eg key-worker or named nurse		
7.6	A written report summarising the individual’s further requirements, and recommendations as agreed during discharge planning, should be circulated to all parties involved prior to or at discharge, within an agreed time frame.		
7.7	The service should have an agreed minimum dataset for documenting outcome from admission, which should be regularly audited.		
7.8	Patients/clients discharged from specialist in-patient services should have access to continued therapy on an out-patient, day-case or domiciliary basis, as is appropriate to their clinical problem and circumstances	7.8	Assessment tools should address handicap as well as disability Outcome monitoring should include an analysis of goal attainment

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7.9	A “named” person within the client’s own locality will be identified and formal contact established prior to discharge	
8	FOLLOW-UP	8 FOLLOW-UP
8.1	All rehabilitation facilities should have a written policy and procedure on follow-up, and this must be consistently applied	
8.2	The service should establish procedures for monitoring whether or not discharge plans are being followed through.	
8.3	Feedback should be provided on follow-up and monitoring of carry-through of discharge plans to relevant parties such as statutory authorities, primary consultant and GP.	
8.4	Best practice would recommend the evaluation of long-term outcomes for all individual’s using validated measures	
8.5	A register should be kept of all patients requiring long term review	8.5 A register should be kept of all individuals with long-term disabilities in the community

9	STAFF DEVELOPMENT / AUDIT AND TRAINING	
9.1	Systems in place within the Trust or host organisation for quality assurance and clinical governance will apply. There should be a system of regular appraisal for all staff	
9.2	All professional staff should be kept up-to-date, and there should be a written policy on training	
9.3	Staff should have local access to up-to-date rehabilitation textbooks and the major rehabilitation journals relevant to their service.	
9.4	Regular training should be available both within and between disciplines, and time should be allocated for training on a regular basis.	
9.5	Since in-house training is unlikely to be sufficient to meet all training needs, adequate funding should be available to allow staff to meet their training needs at external meetings, at least some of which should be multi-professional.	
9.6	Staff should be actively encouraged to attend national conferences, which will afford the opportunity to network with other colleagues both within and outside their own discipline.	
9.7	All services should undertake audit as a routine part of clinical practice.	
9.8	Audit should be undertaken as a multi-disciplinary activity, to encourage dialogue between professions.	
9.9	Audit sessions should be documented, and where change in practice is recommended, a named person should be designated to implement those recommendations.	
9.10	Every opportunity should be sought for multi-disciplinary and inter-agency education and training, including the involvement of patients in management of disability and raising disability awareness.	

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10	LIAISON WITH OTHER HEALTHCARE SERVICES AND AGENCIES (these apply primarily to community services)	
10.1	<p>There should be access to an appropriate range of specialist health care services in acute, mental health and community sectors beyond those provided directly by the rehabilitation and multi-disciplinary team. These may include:</p> <ul style="list-style-type: none"> • Continence and tissue viability services • Wheelchairs and special seating • Environmental control systems and electronic assistive technology (EAT) • Palliative care, occupational health etc. 	
10.2	<p>Rehabilitation services should have clearly identified policies or pathways for:</p> <ul style="list-style-type: none"> • Working with general practitioners and primary care teams (generic services) • Support and specialist rehabilitation for children and adolescents with disabilities approaching adult life • Transfer to care of the elderly rehabilitation services for adults approaching later life • Representing the individuals' interest in community settings, e.g. decision making for those with special care needs or communication deficits whose competence to participate in decisions may require representation from a third party. 	
10.3	<p>There should be agreed protocols for referral to tertiary services or rehabilitation facilities in the private sector, where an individual's rehabilitation needs are beyond the scope of their local services.</p>	
10.4	<p>The community team may potentially have a useful role in supporting individual's during periods of hospital admission, which may include advocacy, education of hospital staff etc. Where appropriate, this is planned and agreed with the relevant hospital units.</p>	<p>10.4 The community teams should have access to acute in-patient services agreed with local providers</p>

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10.5	<p>There should be identified pathways to access and / or work with:</p> <ul style="list-style-type: none">• Social service teams• Housing• Care agencies (including training for care staff for patients with complex needs)• Private sector agencies eg nursing homes• Education and further education including special needs and out-of area provision• Disability employment advisory services and facilities for preparation for work• Financial advice (Benefits Agency, Citizens Advice Bureau, Public Trust Office)• Legal advice (for patients and their families and carers)• Advocacy services – representing the individuals’ interest for those whose competence to participate in decisions about their care and their future is restricted• Charities, self help groups and voluntary agencies• Driving ability assessment centre(s) <p>Multi-disciplinary rehabilitation teams should ensure that they have access to updated information in all these areas.</p>
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