Implementing the Rehabilitation Prescription

This document sets out the conceptual development and some general principles for implementation of the standard rehabilitation prescription within the acute Trauma pathway and associated local rehabilitation services.

Please note:
- This is distinct from the Specialist Rehabilitation Prescription as recommended in the BSRM core standards for specialist rehabilitation following trauma.
- Details of the Specialist Rehabilitation Prescription (SpRP) may be found on the following link: Specialist Rehabilitation Prescription: template for Trauma networks

This conceptual document was drawn up by a working party led by Prof Derick Wade in 2012 with representation from all Major Trauma Centres in England, and also from major interest professional groups.

Very many people contributed, and we do not know the names of most but we would acknowledge the following:

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EXECUTIVE SUMMARY

This document gives advice on how to implement the Rehabilitation Prescription initially proposed by the Clinical Advisory Group on Major Trauma services in its report in September 2010. In December 2012 a working party was convened to develop standards concerning rehabilitation and its documentation, with standards relating to underlying structure (resources), the process and to measuring outcome; details on the evaluation of outcome is being considered by a separate working group. The aim is to improve the quality of rehabilitation so that a better outcome is achieved for each patient.

The document also proposes two specific uses of the standards: to audit service quality, by suggesting data to be collected using TARN (in partnership with UKROC); and to help commissioners, by suggesting specific standards for use for example in quality improvement (CQUINs) or Best Practice Tariffs.

The document concerns all patients admitted to hospital for over 24 hours after trauma, wherever admitted, recognising that this extends beyond some other definitions concerning trauma services. It applies to all services and service providers who are involved with the patient until the end of the rehabilitation pathway. It is relevant to all commissioners, and its implementation will be the responsibility of the Trauma Networks.

The document sets standards that should apply to all rehabilitation. Trauma patients are all managed within rehabilitation services that see patients with many other disorders. Therefore this document should be relevant to all rehabilitation within all NHS services, not simply to rehabilitation after trauma.

The standards primarily focus on process, but structure and outcome are also considered. This document does not propose any particular forms or sets of data, because it is not possible to do this in an appropriate and relevant way while also covering the huge range of clinical situations seen after trauma. A small number of specific data-collection tools are mentioned to help services, but they are not mandated. Some services may prefer to implement this by designing forms. An electronic patient record accessible between all NHS services would greatly improve rehabilitation and its quality.

The document also proposes a series of standards that could be used both to audit service quality, for example within TARN/UKROC, and also could be used by commissioners. Perhaps the key set of standards relates to the Prescription of Rehabilitation Needs, and we recommend that this is particularly audited both in terms of being written, and in terms of the extent to which the needs are met. We emphasise that clinical staff have a duty to state what the clinically justified needs are, even if they cannot be met immediately.

We hope that this document helps clinical teams, service managers, commissioners and patients and that it will be applied to all rehabilitation across all services within the NHS.

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July 14th 2013
INTRODUCTION

In September 2010 the Clinical Advisory Group on Major Trauma services produced a report that recommended the use of a **Rehabilitation Prescription**. The prescription was not clearly defined, nor was implementation discussed. This document outlines how the Rehabilitation Prescription should be implemented in the NHS. It derives from a working party set up by the Clinical Reference Group for Major Trauma in December 2012.

The working party met several times, and circulated draft documents widely within Trauma Networks and to any other interested parties. All comments and suggestions made were considered, and the working party considered many issues. The final drafts were agreed electronically and were then reviewed and agreed by the Clinical Reference Group for Major Trauma services.

The working party agreed that it was neither possible nor appropriate to produce an actual ‘Rehabilitation Prescription’ as a form or **prescription**. It agreed that implementation required the setting of standards relating primarily to the rehabilitation **process**. It noted that the structure of services and the outcome of rehabilitation were both also relevant.

This document sets out the agreed standards that relate to:
- the structure of the clinical multi-disciplinary rehabilitation team
- the process of rehabilitation (timing and procedures)
- the content of clinical rehabilitation documents used by services

It also considers how networks and commissioners might improve the quality of rehabilitation through:
- using the rehabilitation prescription to collect local (individual provider and/or Network) audit data on structure, process and outcome
- selecting certain standards to inform a National Audit
- selecting certain standards to use within the commissioning process.

Although this working party was sponsored by a Clinical Reference Group working within the Department of Health and then the NHS Commissioning Board (now NHS England), the standards should apply anywhere within the UK (and elsewhere) as they are clinical standards independent of managerial arrangements.

THE REHABILITATION PRESCRIPTION

The working party agreed that the Rehabilitation Prescription proposed and outlined by the Clinical Advisory Group was describing **two separate functions**:
- a rehabilitation (disability-focused) clinical record, to run in parallel with or be intertwined with the more traditional medical (disease-focused) clinical record.
- a quality improvement process, being a means to monitor the structure, process and outcome of the rehabilitation process in different populations and/or at different times.

From the original proposal, four separate goals for the Rehabilitation Prescription were identified by the working party:
- to describe all needs relevant to rehabilitation at specified times or situations
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- both immediate and later needs
- whether the needs could be met or not
- without regard to the particular service or organisation expected to meet them

- to engage the patient in the process of rehabilitation
  - and also to empower them

- to ensure that all information concerning management, especially ongoing needs and long-term goals, is transferred at all transitions of clinical care:
  - across services,
  - across all settings,
  - across all agencies,
  - over time, from onset to final discharge

- to improve service quality
  - monitoring process and outcome
  - nationally and within each network

2.2 In summary, the working party concluded that the Rehabilitation Prescription was a revolutionary concept that could not be implemented by simply devising one or even a few specific forms, and/or by setting up rehabilitation services separate from other services. It could only be implemented by setting up a full rehabilitation service across whole systems.

2.3 Therefore the working party agreed that the best way to implement the Rehabilitation Prescription was by recommending standards that should apply to rehabilitation after trauma. The standards concern:

- **structure**, primarily the multi-disciplinary team (other structural requirements arise from the process standards)
- **process**, both in terms of timing and in terms of standards of documentation especially at transitions along the clinical pathway
- **outcome**, in that the recommendations include the need to collect data on outcome and data to interpret outcome, because there are no existing standards. (The actual outcome data to be collected is being considered by a separate working group.)

3.0 **SCOPE OF THIS REPORT**
The Clinical Advisory Group on Major Trauma was primarily concerned with patients who had suffered ‘Major Trauma’, defined as having an Injury Severity Score (ISS) of 8 or more. However this score can only be calculated retrospectively, after many days or weeks. In contrast, rehabilitation must start as soon as possible. Furthermore, the relationship between a patient’s ISS score and their need for rehabilitation score is weak and many patients with a score below 8 (the cut-off used in the service specification) will have significant rehabilitation needs.

3.1 The working party recognised that most current management specifications relate to patients admitted for more than 72 hours, but it agreed that many patients admitted for less than 72 hours had significant rehabilitation needs. Moreover it is at least plausible that giving rehabilitation input to the larger number of people with relatively less severe trauma will have a much greater effect on outcome than improving rehabilitation for the small number of people with severe injuries because these people already receive services albeit not as much as they need.
3.2 Therefore this document applies to all patients who are still in hospital more than 24 hours after their injury, regardless of their eventual classification on ISS score. Furthermore this document applies to these patients until it is agreed that no further rehabilitation needs exist for the particular patient. There is no uniform end point.

3.3 This document applies to all patients regardless of age and type of trauma, including specifically children, the elderly, people with burns, and people with spinal cord injuries.

3.4 Thirdly, this document’s content applies to all clinical teams and services who see patients after trauma including major trauma centres and trauma units, and all other health services whether the patient is an in-patient or in the community, whether funded by the NHS or not, whether managed by the NHS or not. In principle the standards also apply to Social Services as the Clinical Advisory Group emphasised the need for collaboration between Health and Social Services.

3.5 Lastly, because rehabilitation is a process that occurs in parallel with acute medical and surgical management, this document inevitably includes some recommendations concerning the management of trauma after the first immediate phase. The rehabilitation service needs to be aware of the injuries and their medical and surgical management, just as the trauma service needs to know about the rehabilitation process.

4.0 THE NHS CONTEXT (2013)
This document and its recommendations must be seen in the broader context of other relevant work and of current initiatives and health service management processes.

4.1 Many reports and guidelines have commented on the rehabilitation needs of people within health services, and the Rehabilitation Prescription should not be considered as an isolated recommendation from the Clinical Advisory Group. For example rehabilitation features in national guidance of head injuries, long-term neurological conditions, stroke, intensive care, and multiple sclerosis (see references).

4.2 Rehabilitation is also increasing being included within national commissioning guidance and national audits.

4.3 Therefore as far as possible we have made this document consistent with and supportive of:
- specialised commissioning both of major trauma services and of a range of rehabilitation services;
- local commissioning of rehabilitation;
- a large number of existing national documents, for example from NICE, that concern rehabilitation;
- many other official documents such as the National Service Framework for Long-Term Conditions; and
- any standards that might be set, for example in Best Practice Tariffs and in the Commissioning for Quality and Innovation (CQUIN) framework.

4.4 Moreover there are few if any circumstances where patients who have traumatically-induced disability are the only patients seen within a rehabilitation service. As the
Clinical Advisory Group specifically recognised, patients who have rehabilitation needs after trauma will use existing rehabilitation resources alongside patients with similar rehabilitation needs arising from other causes. Therefore any recommendations made in this document must be appropriate to and consistent with processes occurring within existing services. We hope that this has been achieved.

4.5 Conversely the standards developed here could apply to all rehabilitation delivered to all patients within the NHS. Although it was not our original remit, we feel strongly that the standards promulgated in this document should be relevant across the NHS and should apply at a minimum to all patients with sudden onset disability. Indeed, with minor adjustments only, the standards should apply to all people with long-term disability who attend health care services.

5.0 THE REHABILITATION PATHWAY
This document and its recommendations are concerned with the progress of a patient along a rehabilitation pathway starting at the time of trauma and ending when the patient cannot benefit from (does not need) any further involvement from rehabilitation services.

5.1 Rehabilitation
Because many readers may be unfamiliar with rehabilitation, a few basic matters will be covered here. The figure, ‘The Rehabilitation Process – a reiterative cycle’, summarises the process.

5.2 Rehabilitation is a problem-solving process similar to that used in other areas of health care, but it differs in some important ways. Rehabilitation is focused on disability, not disease. It requires a full understanding of all factors that may influence a patient’s performance of functional activities (e.g. dressing, working), both patient-related factors and environment factors, including the social context. It often involves several or many interventions, often given by different professions. Finally the problems of disability usually last longer than the specific treatment of the initial direct injuries, and so contact with rehabilitation usually outlasts contact with specific trauma services.

5.3 Rehabilitation is based upon a comprehensive (holistic) model of illness. The model used across the world is the biopsychosocial model of illness, used for example in the World Health Organisation’s International Classification of Functioning (WHO ICF). This model is described in Wade and Halligan (2004) and Wade (2009), both being easily available. It is also used in the National Clinical Guideline on Stroke and the National Clinical Guideline on Multiple Sclerosis.

5.4 The main domains within the biopsychosocial model are illustrated in the figure and are:
- pathology (changes in structure/function within the body); traumatic damage in this case
- impairment (symptoms/signs, patient experiences, changes in whole body)
- activities (disability, altered or limited goal-directed behaviour)
- participation (social roles, social engagement)
- personal context (patient expectations, attitudes, strengths, etc)
- physical context (including equipment, adaptations, housing etc)
• social context (expectations of others, culture, laws etc)
• temporal context (time in life and time in illness)

5.5 There will be no further description of these domains here. They are described more in the references.

5.6 The process of rehabilitation is also described elsewhere [Wade (2009), Wade (2005)]. It has the same stages as medical or surgical management of disease. The process will only be outlined briefly here. It involves:

• **assessment**, the collection and use of data to formulate (understand, analyse) the situation and to identify potential goals and interventions
• **setting of goals** with the patient that are guided by the patient’s wishes and priorities, and by what is achievable. Goals should be set for the immediate future, the medium term and the long term and they may cover potentially all domains of the model of illness mentioned above (5.4)
• **actions and activities** to include both provision of care (support) to maintain safety and well-being, and treatments that alter the eventual outcome. This can include:
  o patient-centred actions: increasing abilities, helping adaptation, providing support and information etc
  o environment-centred actions: altering structure, providing equipment, teaching carers etc
  o family-centred actions: disability rarely affects the individual alone, and families too may need emotional, practical or informational input.
  o Information-centred actions: liaison with other people, teams and agencies
• **review, evaluation and reassessment** at an appropriate time, with reiteration back through goal setting if needed.

5.7 The main point to note is that there is a distinction between

• care (support), anything needed simply to preserve safety and well-being (life), and
• treatment which is time-limited and aims to alter outcome.

5.8 The primary active intervention processes are:

• teaching/learning and practicing activities, which involve the patient (and family), and
• altering the context (environment), and
• liaising with other clinicians, teams or organisations including outside Health. This is often a large component of the work.

5.9 **The Rehabilitation Pathway after trauma**

The time course of the rehabilitation process is very unpredictable in most situations, especially in the first few weeks. The outcome after trauma is also very unpredictable, again especially in the first few weeks. Nonetheless in principle all rehabilitation should come to an end, with the patient having the option to return if necessary.

5.10 This unpredictability and variability arises for many reasons:

• the nature and severity of the trauma is very varied
• the patients vary in their pre-existing medical and physiological state
• the psychosocial situations of patients vary greatly
• even within a group of patients with similar injuries, the natural history of recovery is very variable between patients.

5.11 Thus it is not possible to define any single or small number of specific rehabilitation pathways that will be followed by patients, even with similar initial trauma; the main exception is complete spinal cord injury.

5.12 Instead each patient’s pathway will evolve over time, and the primary requirement of services is for them to be sufficiently available, varied and flexible to be able to meet the needs of a patient once needs are identified. A need refers to actions that will benefit the patient. A need is not determined by what the patient wants to have or by what the service wishes to provide; the action must alter the natural history in a way that benefits the patient.

5.13 Throughout a patient’s progress down the rehabilitation pathway it is essential that he or she is under the care of a multi-disciplinary rehabilitation team with the appropriate expertise. This will ensure:
• full, early and continuing identification of all of the problems that need to be considered and resolved
• determining the possible outcomes in the long-term
• setting appropriate expectations (for patient, family, other services etc)
• setting of appropriate immediate and long-term goals
• specification of all immediate and middle-term needs (actions that will benefit the patient)
• direct provision of interventions and/or referral on to and/or additional involvement of appropriate other services often managed by other organisations both in the NHS and outside health
• monitoring and evaluation of change.

5.14 The relationship between the rehabilitation pathway and various prescription standards is shown in the following figures:
• Rehabilitation process and prescriptions: first four days
• Rehabilitation prescription, first six months, all settings and all services
• Transitions along rehabilitation and recovery pathway

6.0 APPLIES TO ALL PATIENT GROUPS
This document concerns how rehabilitation services should be delivered in terms of the process of rehabilitation. It also concerns the content of clinical rehabilitation records. The document is not intended to define how services are organised, and should not be interpreted in that way.

6.1 A few comments will be made to illustrate the intention and to suggest some likely variations.

6.2 There is inevitably going to be a separation of services for children aged up to 16 years. Their clinical needs will differ, for example to take into account the importance of educational services and the importance of natural development and maturation over time. Separation of paediatric services is also a statutory requirement. Therefore
different aspects of these standards and recommendations will apply to the implementation of these principles in paediatric services.

6.3 Within adults, there are already many different services. There are specialised services for people with spinal cord injuries, though these services cannot currently manage all patients as promptly as needed nor do they manage many patients with other spinal cord pathologies. There are a very small number of specialised neurological rehabilitation services, completely insufficient for the large numbers of patients with brain injury from trauma, let alone other causes. There are some services focused on elderly people with fractures (orthogeriatric services).

6.4 It is likely that, dependent upon local resources, most of the acute and early phase rehabilitation will be the responsibility of integrated rehabilitation services within the acute trauma services, able to manage most adult patients either completely or until they move to a more specialist service. The situation for children is less clear, but usually they will come under a paediatric rehabilitation service run within general paediatric services.

6.5 Thereafter the patient may move into other specialist (Level 1 or 2) rehabilitation services or may not receive any specialist rehabilitation service. Known specialist services include those for people with burns, neurological damage, spinal cord injury and amputation. In the UK specialist services for patients with complex musculo-skeletal problems are rare or non-existent.

6.6 It is hoped that the standards developed here will apply to any and all of the services available to and used by patients after trauma. Minor additions and clarification will inevitably be needed as the document is used, in the light of experience. Some specific additions, changes or omissions will become needed both with experience and as services develop.

7.0 THE STANDARDS – introduction
The working party agreed that the only way to implement the ideas set out in the original report was to set out standards of practice covering all aspects of rehabilitation. Therefore the remainder of this document discusses a series of standards relating to structure, process or outcome. The main report sets out principles and the appendix gives more detailed and itemised standards.

7.1 The standards concerning documentation are referred to as Rehabilitation Prescriptions, each then annotated with a specific situation (e.g. initial review, transfer between services). They are referred to as, for example, ‘RP: initial registration’. This terminology was used to capitalise on the new term introduced by the Clinical Advisory Group.

7.2 Structure
The primary structural matter relates to the multi-disciplinary team.

7.3 Process
Most of the standards relate to improving the process of rehabilitation.
7.4 There are standards that concern
- **timing** of events
- **transitions** along the pathway, including leaving the rehabilitation pathway (discharge)
- **content** of documents at certain times or transitions (the family of Rehabilitation Prescriptions)
- **transfer of information**
- providing **quality control data** for management organisations

7.5 **Outcome**
This document does not set any actual standards for outcome, but does suggest how implementing the Rehabilitation Prescription could facilitate collection of standardised outcome data.

8.0 **STRUCTURE – THE MULTI-DISCIPLINARY TEAM.**
The multi-disciplinary team is central to rehabilitation, and without such teams rehabilitation will never be very effective, or efficient. There is considerable debate both about the necessary membership of such teams, and about the level of expertise of team members. The evidence suggests that a broad team with considerable expertise and specialism is most cost-effective.

8.1 Recommendations on the structure of teams have been made in several national documents such as the National Clinical guideline for stroke, the National clinical guideline for people with multiple sclerosis and the British Society of Rehabilitation Medicine. These generally apply to specific groups of patients.

8.2 It is obvious that the numbers and proportions of different professions within a team will vary in different services according to the clinical work undertaken. For example prosthetists would be essential within a service for amputees but not elsewhere, dieticians will be essential in acute trauma wards, and teachers will be part of the team for children. As the needs of an individual patient reduce then the size of the actual team involved with that patient may reduce but the whole team should remain available to that patient if needed.

8.3 Nonetheless it is possible to specify the characteristics of a team that should be available to most patients.

8.4 For trauma rehabilitation a reasonable set of criteria to identify a **multi-disciplinary team that is of a suitable minimal standard** would be that it:
1) is composed of staff who have specialist knowledge and skills in rehabilitation appropriate to the patients seen (initially acute trauma, but later on in the group that the service selects and manages)
2) contains as members of the team all the professions needed to resolve at least 80% of the problems met in the patients managed (Wade, 2000).
3) should usually include as a minimum staff with certified specialist training in rehabilitation of the specific patient group from the following professions:
   a) doctors (see 8.7 – 8.10 for discussion on speciality)
   b) nurses
   c) physiotherapists
   d) occupational therapists
e) clinical psychologists  
f) speech and language and/or other specific therapists (including orthotists, dietitians, teachers for children etc)  
g) social workers  
4) is managed and funded as a single group of staff  
5) has a single geographic base for all team members to use  
6) has regular meetings as a group to discuss  
a) individual patients, usually weekly, and at goal setting meetings if needed  
b) team policies, training etc  
7) works within an agreed common framework, the biopsychosocial model of illness, and uses a common terminology  
8) uses agreed protocols and procedures for common clinical problems, including working across professional boundaries and sharing assessments.

8.5 Rehabilitation teams must be large enough in terms of staff numbers to cover holidays and sickness and not to be disrupted when one experienced member leaves. This particularly applies to the small group of high cost patients requiring the expertise and facilities of specialist rehabilitation services (level 1 or level 2) and standards for these nationally-commissioned services have been developed by the British Society of Rehabilitation Medicine (BSRM).

8.6 Therefore the **one standard for structure** is that:  
- from the time of onset, every patient should have access to a specialist multi-disciplinary rehabilitation team that  
  o fulfills the criteria given above  
  o meets their rehabilitation needs with the required level of organization (quality)  
  o meets their rehabilitation needs with the required amount of input (quantity)

8.7 **Consultant in Rehabilitation Medicine**  
The working party and comments made by others illustrated a considerable and continuing debate about the nature of consultant level input into the rehabilitation team.

8.8 It was agreed easily that:  
- There must be full consultant-level input into the rehabilitation team, including taking full responsibility for initial assessment  
- The consultant must have full, high-level rehabilitation knowledge, skills and experience appropriate to the clinical situation  
- All patients who were potentially going to be categorized as needing specialist rehabilitation funded through specialized service commissioning had to be seen by a Consultant in Rehabilitation Medicine, as specified by the contract.

8.9 The primary issues concerned (a) older patients with multiple morbidity where the trauma was symptomatic of long-standing frailty and (b) specific groups of patients such as those with burns, and children.

8.10 The current suggestion is that the Consultant in Rehabilitation Medicine should be the initial rehabilitation contact, but that rehabilitation responsibility can then be passed on
to another consultant either completely, or in continued liaison with the Rehabilitation consultant. This requires the second consultant to have appropriate knowledge, skills and experience, usually evidenced by appropriate training and ongoing professional development in rehabilitation practice, knowledge and skills.

9.0 PROCESS – TIMING AND FREQUENCY
The specialised service specification for major trauma services sets out some standards for the first four days and the working party agreed that they were appropriate and achievable. They are included within the standards given here.

9.1 The first set of standards relates to the first four days, and it is that:
• Every patient who is in hospital after trauma for more than 24 hours (no exceptions) should
  o have an initial assessment by a senior member of the multi-disciplinary rehabilitation team within 48 hours (registration)
  o be assessed by a consultant in rehabilitation medicine within 72 hours
  o have a full multi-disciplinary rehabilitation assessment to identify needs by 96 hours

9.2 However most patients will have rehabilitation needs extending beyond four days and many patients will need and receive rehabilitation for weeks and months. While a patient is receiving rehabilitation formal, documented reviews should occur to monitor changing needs and evaluate treatments.

9.3 Therefore the second set of standards relates to the frequency of formal reviews of a patient’s situation while on the rehabilitation pathway. The standard set is that:
• every patient actively involved in the recovery and rehabilitation process after trauma should have a documented rehabilitation review at a minimum frequency of:
  o every week over the first six weeks
  o every four weeks from 6 weeks to six months

9.4 It should be emphasised that the review associated with a transition (next section) should be considered a rehabilitation review. Also this does not preclude more frequent reviews.

10.0 PROCESS – TRANSITIONS AND DISCHARGE
One characteristic of rehabilitation after trauma is that patients are often cared for by a succession of services in a variety of different settings. Good transfer of information is essential. This set of standards relates to transitions between services and settings.

10.1 The first set of standards relate to the service transferring a patient out, and they are that:
• The service transferring out a patient who has continuing disability and rehabilitation needs should:
  o identify and specify (record) the rehabilitation team responsible for continuing rehabilitation input in the next setting and/or service
• Every patient still receiving or needing rehabilitation after trauma (i.e. not yet formally discharged) who moves from one service, team or setting to another (even if still within a single organisation) should be accompanied by:
10.2 The second set of standards relate to the service receiving a patient. They are that:
- Every service receiving a transferred patient who has continuing disability and rehabilitation needs after trauma should:
  - record formally that they received a transfer set of information;
  - if information is not received then they should contact their local rehabilitation service and ask for a copy of the full review, or as much relevant information as possible
  - undertake a full review of rehabilitation needs
  - inform the Trauma Network rehabilitation board by an agreed route
- review the suggested rehabilitation needs:
  - recording any significant change/disagreement
  - recording the extent to which each need can be met, the reason for any short-fall, and what action is being taken to meet unmet need
  - informing the Trauma Network rehabilitation board on the extent to which needs will be met, and the reasons for any shortfall
- send feedback to the transferring service on the quality of the information provided

10.3 The working party noted that the Rehabilitation Complexity Scale – Extended Trauma (RCS-ET, RCS v 16) was developed as a way of recording both the rehabilitation needs of a patient and also the extent to which those needs are met. It therefore recommends that the RCS-ET is used as an integral part of the documentation when transferring patients with significant ongoing disability. This will simplify assessment, and standardise communication.

10.4 The last set of standards in this section relate to patients who reach the end of their rehabilitation pathway. In this context discharge is defined as the point at which the rehabilitation service:
- has not identified any further goals for treatment or other rehabilitation needs, and
- does not have any further planned contact with the patient for active rehabilitation

10.5 The standards for discharge are that at the time of discharge from rehabilitation:
- every patient should have copies of documents that:
  - list all injuries sustained
  - identify any ongoing care and support needs, including drugs and equipment
  - identify any specific risks or other matters of concern
  - specify who to contact, and how in the event of any problem arising
- the general practitioner should have copies of the same set of documents

10.6 It is not necessary to provide again documents that have already listed the injuries, provided that it is known that the patient and the GP have a full list.
11.0 PROCESS – CONTENT OF DOCUMENTS
The next sets of recommendations concern the information that should be collected and documented at various points along the rehabilitation pathway. This section is related to a series of tables at the end of this document showing the details. This section considers the goals of each set of standards; the detailed lists in the appendix for each prescription itemises the standard.

11.1 First four days after trauma
The first set of standards concern the early involvement of specialist rehabilitation services with the patient. The time limit set in the current (2013/14) service specification is 96 hours from time of trauma. (see figure Rehabilitation Process & Prescriptions: first four days).

11.2 The standards recognise that some patients may require some time to be assessed adequately, but at the same time other patients may be discharged or at least transferred within 96 hours. Consequently we have made two sets of recommendations to ensure early rehabilitation input while allowing time for proper assessment where needed.

11.3 This requires a distinction between registration and initial assessment. The former is a minimum required by 48 hours, the latter a full assessment, which can be completed at any time in the first 96 hours. These can be done simultaneously at 48 hours if circumstances allow.

11.4 RP: registration
The goals of this set of standards are to ensure:

- Early contact with a multi-disciplinary rehabilitation service so that appropriate interventions and plans are started as soon as possible
- That every patient is seen by and becomes known to the rehabilitation service, without exception
- A full list of injuries is readily available in one place from an early time.

11.5 RP: initial assessment
The goals of this set of standards are to ensure:

- An early assessment of rehabilitation status and needs
- That patients who have no rehabilitation needs are documented as such for other services and professions
- A minimum documentation of relevant background factors for any ongoing rehabilitation

11.6 We recognise that some patients may be appropriately discharged home within 48-96 hours. Ideally a full initial assessment should occur before discharge but it would be reasonable to arrange a very early out-patient rehabilitation review if a full assessment cannot be achieved.

11.7 Regular reviews
The working party considered that good clinical rehabilitation practice included both:

- regular reviews of
  - progress towards goals, and of
Implementing the Rehabilitation Prescription.  

11.8 Ideally each team seeing an individual patient should set an appropriate interval for the next review, determined by the patient’s situation. In reality this will rarely occur. Consequently we have set some standards concerning the frequency of reviews (see 9.3), and the content of the reviews (below).

11.9 Two key sets of clinical information were identified: the rehabilitation status, and the rehabilitation needs. These sets would be the same whether collected as part of a time-based review within a constant setting or at the time of a transfer to another service.

11.10 RP: rehabilitation status
The goals of this set of standards are to:
• Record major events and/or changes since last status document
• Document explicitly the patient’s level of impairment and activities at the time
• Ensure that significant impairments and activities are not overlooked
• Identify all ‘hidden’ problems such as risk, emotional disturbance and limitations on mental capacity

11.11 RP: rehabilitation needs
This is the central document, and the goals of this set of standards are to:
• state any immediate treatment needs for the injuries
• outline relevant background information for setting rehabilitation goals
• state current goals, and actions needed to achieve those goals
• record onward referrals made or needed, and any ‘best interests’ decisions
• audit the extent to which needs are met

11.12 The working party recognised that the format of any documents was likely to vary widely according to local preferences, the nature of the service, the nature of the patient group, and the availability of useful and adaptable electronic clinical records. Often it will be appropriate to archive a previous set of review documents and then to update them to record the current situation.

11.13 Transitions/transfers of care
One key weakness identified by the Clinical Advisory Group was in handing on information about the patient when they moved from service to service – in other words, across transitions. (See figure Transitions along rehabilitation and recovery pathway.) The lack of information covered almost everything – injuries, medical management and particularly rehabilitation. It also covered historical information (i.e. what had happened so far) and psychosocial information.

11.14 The working group considered that standards should be given for all transitions, including when a patient moved from one service to another or one setting to another within the same organisation. Information transfer is also important when patients move out into the community, and at the time of the ultimate transition, discharge, when a patient’s management transfers from healthcare to the patient him or herself.
11.15 The goals are to ensure that the new service has all required information about:
   • injuries and their specific management and prognosis
   • ongoing physiological care needs
   • overall prognosis and patient goals
   • current rehabilitation goals
   • any identified plans, risks etc

11.16 These standards apply to the documents that accompany the patient during a process of transfer. The standards are that:
   • whenever clinical responsibility for a patient passes from one clinical team in one place to a new team in a new place, regardless of whether there is an associated change in the organisation responsible, the patient should be accompanied by a transfer set of information which should include
     o RP: initial assessment and RP: registration
     o RP: rehabilitation status (current at time of transfer)
     o RP: rehabilitation needs (current at time of transfer)
     o RP: transfer
   • the transfer set of information should be accompanied by a form requesting feedback on the information transferred, with a copy being sent to the Network coordinator

11.17 **RP: transfer**
   This is an additional set of information associated with the transfer, and the goals are to:
   • record the service management details
   • identify specific medical and physiological care needs (to minimise risk at time of transfer)
   • highlight information given to patient and family

11.18 **Discharge**
   Almost every patient will or should eventually be discharged from secondary care or specialist community care services. Discharge is most easily defined as a time when no further planned service-related appointments exist; this excludes any follow-up or data-collection arranged for non-clinical reasons.

11.19 In practical terms discharge will also include situations when a patient no longer has an appointment related to planned treatment but:
   • the patient is told that they may come back if needed and/or if a defined event occurs
   • the service does a routine check, often by phone or letter at six or more months after discharge

11.20 These standards apply to the documents that accompany the patient at the time of discharge, and they are that:
   • when the patient is discharged, a discharge set of information should be prepared, which should include
     o RP: initial assessment and RP: registration
     o RP: rehabilitation status (current at time of discharge)
     o RP: discharge
11.21 **RP: discharge**
The goals of this are to:
- state and confirm explicitly that no further rehabilitation needs exist
- identify any events or situations that might require further involvement of services
- identify how contact should be re-established if needed
- specify any ongoing care and support needs
- inform all previously involved services of the final outcome

11.22 **‘Specialised Commissioning’ of rehabilitation services**
After trauma small minority of patients, probably less than 5%, will have such complex or severe problems that they require highly specialist services. (e.g. patients with spinal cord injury). This section is only relevant to this minority.

11.23 Over the last few years a framework for describing and commissioning rehabilitation services has been developed [BSRM, Levels of specialisation in rehabilitation services]. This has been used as the basis for commissioning and funding some more complex rehabilitation services in 2013/14. It recognises three levels of service ranging from level 1 (highly specialist) to level 3 (generic) and four levels of patients need ranging from Category A to D:

11.24 The commissioning guide suggests:
- Category A patients have highly complex needs requiring a Level 1 specialist rehabilitation service but potentially met in a level 2a service
- Category B patients have moderately complex needs requiring a Level 2b local specialist rehabilitation service
- Category C patients have rehabilitation needs that can be met by a level 3a service
- Category D patients have needs that can be met by a level 3b service.

11.25 Currently the commissioning framework only recognises specific commissioning for *specialised rehabilitation* in the context of in-patient services usually in specific centres that are classified as providing ‘level 1’ or ‘level 2a’ services. Outreach initial assessments, research and educational support are included within the expected services of a level 1 service.

11.26 The specialised commissioning framework requires individual patients to be classified as requiring level 1 or level 2a or level 2b inpatient services, and it then requires these patients to have a particular set of information collected and submitted to the UK Rehabilitation Outcomes Collaborative (UKROC) database. This information is required at the time of classification, and then some information is required at regular defined intervals (currently every two weeks) while an inpatient.

11.27 Specialised Rehabilitation services should adhere to the general standards outlined in this document. In reality, much of the data required by commissioners from specialised rehabilitation services is additional to the standards noted here. The existing general rehabilitation standards published by the British Society for Rehabilitation Medicine also exceed the standards noted here.
In brief, services commissioned to provide specialised rehabilitation at level 1 or 2a will need to follow the required procedures as laid down in the service specification for specialised rehabilitation:

- use the Patient Categorisation Tool to justify the clinical decision by a consultant in rehabilitation medicine and several other professions to place patients in categories A or B (i.e. requiring specialised rehabilitation).
- for these patients additional data will need to be collected, as required by Specialised Commissioning, including:
  - Northwick Park Nursing Dependency Scale
  - The Neurological Impairment Scale – Trauma (version 9)
  - Rehabilitation Complexity Scale – Extended Trauma version (RCS-ET)
  - The FIM/FAM (Functional Independence Measure and Functional Assessment Measure)

Further details about the UK Rehabilitation Outcomes Collaborative (UKROC) and the datasets, including many of the assessment forms is available at: http://www.csi.kcl.ac.uk/ukroc.

The Rehabilitation Prescription is also intended to improve the outcome by collecting data on process and outcome for all patients seen across an individual trauma network and in England as a whole.

In general terms the patient-level data needed should cover:

- **intake**: case-mix, factors that have a large impact on process measures being recorded and outcomes being recorded. It is very unlikely that the International Severity Scale (ISS) score will be a useful measure in this context, requiring other data to be collected that relates to outcome from disability and rehabilitation.
- **process**: this is likely to be the most useful data, and covers such matters as delays in accessing suitable services or other resources, gaps in services available, and level of and amount of expert rehabilitation input given.
- **outcome**: this is the most relevant in many ways, but difficulties in collection and in interpretation make it an unrealistic method for monitoring quality, with one exception: monitoring **avoidable adverse events**, such as the development of skin pressure ulcerations or skin pressure ulcers may be a good indicator of service quality.

The outcome data required nationally for all trauma patients is the subject of a working group and has yet to be finally confirmed, but it is likely to include:

- EuroQol (EQ5D)
- Glasgow Outcome Scale Extended (GOSE)

Specific data is also an absolute requirement for people being treated in level 1 and level 2 services commissioned by specialist commissioning. The **outcome data** includes the FIM/FAM (Functional Independence Measure and Functional Assessment Measure).

Trauma Networks will need to define the outcome data that they wish to collect, if any.
12.4 Outcome data should be collected from as many of the eligible population as possible, and this will be a major problem given the population. For any data set being collected, there will need to be discussions about how data are collected, who will be responsible, who will pay for the data collection, who will collate and analyse data etc. The Trauma Audit and Research Network (TARN) is likely to play a key role.

12.5 The RP quality control prescription suggested here is very general, but does include current expectations for national data as well some other ideas.

12.6 **RP: Quality control**
The goals of this are to:
- collect sufficient data on patients to allow
  - interpretation of outcome in a particular cohort
  - description of patients for comparison with other centres or over time
- monitor the process of care and transition along pathways
- record outcome in all patients at an agreed set time after trauma (to allow interpretation)

13.0 **REHABILITATION PRESCRIPTION: PRACTICAL MATTERS**
So far the document has considered matters of principle. This section discusses some practical matters.

13.1 **Copies, distribution.**
One major concern of patients, families and clinicians is that information is often not transferred between services. Given that currently there is no single, simple web-based electronic record that can be accessed by different services in different places, a system of transferring information is essential and it will inevitably depend upon paper copies.

13.2 A second associated concern is that services, and particularly the Network itself have no reliable way of tracking patients as they move, for example when assessing outcome or when evaluating the integrity and quality of the whole patient pathway. A system of notifying a central administration about all transfers is needed and in the absence of any web-based electronic record again paper will be used.

13.3 Last it is now recommended that a patient should be given copies of all correspondence and other communications – “Nothing about me without me.”.

13.4 Consequently we have recommended that at least some of the records should be copied to others, including the patient or their family or other representative.

13.5 Some documents will need copying and distributing immediately but generally copies will only be needed at the time of transfer. We indicate what copies will be needed, and who will need them but the timing of production and sending of these copies will depend upon the circumstances.

13.6 The patient could potentially collect a large volume of paper. Networks and services should consider providing each patient who is involved with a file or folder, which could also contain more generic information about appropriate local service – statutory and voluntary.
13.7 Each network board will need a manager or coordinator and the network will need to agree with network members how data are to be collected. In this document we suggest that copies are sent to ‘the network coordinator’. Each network will need to agree who is responsible for collecting and collating process and outcome data, and the mechanism(s) and route(s) of data transfer will need local agreement.

14.0 DATA COLLECTION TOOLS

Because this document is applicable to all patients who have had trauma, regardless of severity, type of trauma, age etc, we have not designed a ‘rehabilitation prescription’ form, nor have we suggested that any specific data collection tools (assessments, measures) should be used, with the exception of the Barthel ADL index for hospital inpatients.

14.1 However we also recognise that most clinical teams will not be aware of or familiar with the range of tools available. Therefore in this section we will cover some of the data collection tools that are available.

14.2 We are recommending that each tool should be used only when it is appropriate to use the measure. Each measure is useful only to provide particular information, and it should only be used in those limited circumstances. We must emphasise that these are not mandated, and that it is perfectly reasonable to use alternative tools provided they achieve the same goal.

14.3 We anticipate that most of these tools will be available on the Trauma Audit and Research Network (TARN) website and become incorporated into the TARN database so that they can be used on-line and printed out, thereby simultaneously entering useful data and having a clinical record.

14.4 The tools will be named here with a brief comment on when it might be appropriate to use them, linking them to the standards and prescriptions mentioned.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Purpose</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Complexity Scale – extended trauma (RCS-ET)</td>
<td>This tool records: • medical, nursing and therapy needs • extent to which needs are met</td>
<td>This would be appropriate for recording rehabilitation needs - initially and at each transfer - while in hospital at each review It is mandatory every two weeks for patients during level 1 and level 2 specialist rehabilitation</td>
</tr>
<tr>
<td>Medical needs (part of RCS-ET). ‘M-score’</td>
<td>To record level of medical care needed</td>
<td>To help judge when a patient could safely be transferred to a predominantly rehabilitation environment</td>
</tr>
<tr>
<td>Barthel ADL index</td>
<td>To record dependence in ten personal activities of daily living. May help in organising staffing</td>
<td>This would be appropriate to use at all regular review while a patient is in hospital</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>To record in more detail the</td>
<td>This is required before acceptance into</td>
</tr>
</tbody>
</table>
Implementing the Rehabilitation Prescription.  

15.0 TRAUMA AUDIT AND RESEARCH NETWORK (TARN)

The Trauma Audit and Research Network (TARN) database is already being used to collect data on all patients in the acute phase. These data are primarily aimed at monitoring and improving the quality of the very early acute management. Rehabilitation Prescriptions are currently available on the electronic Data Collection and Reporting system (eDCR). However there are only four data items concerning rehabilitation that are required to be completed for the evaluation of patient care for Best Practice Tariff (BPT) purposes.

15.1 However the TARN database is or will be accessible across all services and thus it offers an ideal opportunity to collect data on the process of rehabilitation over time, and also to track patients through links with the UKROC database. This latter function will facilitate the collection of long-term outcome data, which will also be undertaken using TARN.

15.2 This section outlines some potential sets of data that could be collected by TARN.

15.3 Preconditions.

For TARN to be an effective means of collecting data and auditing rehabilitation:

- every patient who fulfills the TARN inclusion criteria should be submitted to the eDCR.
- all patients admitted through Trauma Units will also need to be registered on TARN, and to have data entered.
- every service within the Network will need to be able to access TARN in order to enter data (and hopefully to see relevant data about a patient).

15.4 At present the TARN inclusion criteria exclude patients who are discharged within 72 hours, and may exclude other patients who have significant rehabilitation needs after trauma. Eventually the criteria may need to be reviewed and revised to include more people who need rehabilitation, recognizing that TARN cannot record every person attending hospital with trauma.
15.5 **Data to be collected.**
We suggest three separate sets of data.

15.6 The first set concerns the first four days (up to RP: initial assessment). This will almost always be completed by the first centre the patient attends (Major Trauma Centre of Trauma Unit). The dataset is shown in the first ‘TARN Table’ in the appendix. The goal is to audit how complete the initial assessment and rehabilitation process is.

15.7 The second set of data concerns each and every services involved along a patient’s pathway. It requires every service involved along a patient’s pathway to record the standard of transfer in, and transfer out, and the standard of rehabilitation given while the patient was under their care. It is completed at the time of transfer out.

15.8 This set should always be adding to an existing patient record, although it must be recognized that not every patient will necessarily be registered with TARN by the Trauma Unit.

15.9 The third set concerns the process and documentation of discharge from rehabilitation.

15.10 In principle these repeated sets of data will allow the network to track a patient’s progress and identify service deficiencies. It should also facilitate obtaining outcome data.

15.9 **Responses.**
There are always two responses for each question, Yes or No, but there is a third possible response in some circumstances, “No but ..”. This allows for explanation of some failures (i.e. when the answer might be ‘not applicable’). However when data are simply not recorded, the answer must be “no”.

16.0 **SELECTED STANDARDS FOR USE IN COMMISSIONING**
Commissioners could potentially use the standards in this document to develop incentives for providers to improve rehabilitation. For example achieving one of the standards outlined here might be used in a Best Practice Tariff, or a standard might be used in a CQUINN.

16.1 Only one or two standards can be used as an incentive in commissioning at any one time. Nonetheless we will recommend rather more, covering different aspects of the process so that commissioners can choose to focus on particular aspects of rehabilitation according to local circumstances.

16.2 Unsurprisingly most of the standards suggested for commissioning are also in the list of TARN audit data to be collected, because both commissioning and audit are trying to improve the quality of rehabilitation and both need key ‘markers’ of a better standard. Having the same standards does mean that providers should already have systems in place to collect data, making it easier for commissioners to use the standard.

16.3 The standard will be expressed as ‘all’ or ‘every’ patient, but in the context of measuring quality it is unrealistic to expect 100% achievement for several reasons:
incomplete registration, unavoidable clinical reasons, other circumstances. Where necessary, we also suggest the evidence required.

16.4 Therefore commissioners will need to set appropriate percentages. We would suggest the lowest is about 50%, which will encourage the many organisations who do not have specialist rehabilitation services to start developing them. The second could be 70%, which will encourage fuller development. And the top could be 90%, which makes allowance for some inevitable lapses without penalizing. However commissioners could choose other limits, and may need to be guided by early TARN data.

16.5 **Specialist rehabilitation service provision.**
These are intended to improve the quality of rehabilitation given to patients throughout their rehabilitation, by concentrating on the *structure* of rehabilitation resources: 16.5a covers the **acute phase rehabilitation**, and 16.5b covers all **subsequent rehabilitation**.

16.5a Every patient (who has had trauma within last six months) managed within the organization (or the Network) should be able to have a full specialist rehabilitation assessment covering their rehabilitation status and needs within four days of admission (after trauma) or transfer in to a new service. **Evidence** for this would be job descriptions covering all the necessary professions, each job description indicating that the person belongs to a specified rehabilitation team.

16.5b Every organization managing people with trauma should have within the organization a specialist rehabilitation team that fulfills the criteria laid out in the Rehabilitation Prescription document. This applies, whatever the organization’s primary role or function is. **Evidence** for this would be a set of job descriptions covering all necessary professions and each indicating that the person is a member of a specified rehabilitation team.

16.6 In the second standard (16.5b) the percentages could be:
- 50%: doctor or nurses, and at least two other professions
- 70%: doctor and nurses and three other professions
- 90%: full team and a specific rehabilitation ward available within the organization

16.7 **Acute phase**
These are specifically intended to ensure immediate provision of rehabilitation, focusing on the *process* of rehabilitation.

16.7a Every patient should be seen and registered with a specialist rehabilitation service within 48 hours of admission. Registration means that the rehabilitation service accepts responsibility for the rehabilitation needs of the patient until (a) there are no residual needs or (b) the patients transfers to a different organization. **Evidence** would be a formal entry in the notes recording the initial contact and indicating future contact. This would come from the TARN audit.

16.7b By discharge or by 96 hours, whichever is earlier, every patient admitted after trauma should have a full assessment by at least two senior members of a specialist rehabilitation team in liaison with a consultant in Rehabilitation Medicine or their
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designated deputy. Evidence would be the initial rehabilitation prescription, again coming through the TARN audit.

16.8 **Ongoing rehabilitation.**
This also focuses on the process of rehabilitation, and especially applies to patients seen in Trauma Units and patients transferred back from major trauma centres to more local hospitals. The goal is to ensure a high standard of rehabilitation throughout a patient’s journey after trauma.

16.8a Every patient in the organization who has rehabilitation needs should have a formal multidisciplinary review by a specialist rehabilitation team every 7 days in the first six weeks, and every 4 weeks thereafter. Evidence for this will be a full rehabilitation status and rehabilitation needs assessment at each time point, which should be recorded in the TARN audit data for the episode of care.

16.8b Every patient needing rehabilitation after major trauma should have the relevant rehabilitation data items entered onto the TARN database, and submitted to the UKROC database if the patient has confirmed category A needs. Evidence for this would be an entry to the relevant database(s).

16.9 **Transfers and discharge.**
This applies to all organisations within a network, and should be applied to any organization being commissioned to provide any healthcare to patients after trauma (not simply to those providing rehabilitation).

16.9a Every patient who is being seen following trauma and who is transferred from the organization to another organization should be accompanied by the full set of information specified in paragraph 11.16 of this document. Evidence for this would be a copy of the information being either in the notes of the receiving organization or (less satisfactory) in the notes of the transferring organization or (best) with the Network data collection centre, if it exists. The TARN audit should include relevant data from both the service transferring out and the receiving service.

16.9b When a patient is discharged from rehabilitation, having no further needed or planned rehabilitation actions, the set of information specified in paragraph 11.20 of this document should be given to the patient and to the general practitioner. Evidence for this would be that copy within the patient notes of the discharging service, supported by TARN audit data.

16.10 **Network**
This applies to the Trauma Network, which is currently the responsibility of the Major Trauma Centre.

16.10a The Trauma Network should have a system for collecting data on each patient’s pathway using the rehabilitation prescriptions produced at each transition and at discharge. Evidence for this would be regular reports arising from analysis of network activity.

17.0 **SUMMARY AND CONCLUSION**
This document has outlined a series of standards concerning the structure and process of rehabilitation after trauma. These can be used to audit the quality of rehabilitation provided, and could be used to guide commissioning of rehabilitation after trauma.

17.1 More importantly, the principles and standards apply equally to all people who have rehabilitation needs, whether after other acute illnesses such as stroke or hypoxic brain injury, or as part of a long-term disabling condition such as osteoarthritis, cerebral palsy or motor neurone disease.

17.2 This document should only be the starting point for a major improvement in rehabilitation services for all patients in the UK, however funded and whatever the nature of their disabling condition.

17.3 First, as the recommendations in this document are used they should be refined and improved in the light of experience. A formal review after one year (September 2014) is suggested.

17.4 Second, at the same time, specialist societies such as the British Society of Rehabilitation Medicine in conjunction with other professional societies could start to develop more specific standards, and more specific general guidance for example on appropriate assessment protocols for different clinical situations. This could be discussed at the formal review in September 2014.

17.5 Third, the content of the document should be considered by other agencies concerned with people who have a disability and who may need rehabilitation or specialist help. This includes Social Services, Education and Employment services.
### APPENDIX – list of contents

RP: = Rehabilitation Prescription

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<th>Content and comment</th>
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|      | • list of standards (by 48 hours) |
| 29   | RP: initial assessment  
|      | • list of standards (by 96 hours) |
| 31   | RP: rehabilitation status  
|      | • list of standards (at each review and transfer) |
| 32   | RP: rehabilitation needs  
|      | • list of standards (at each review and transfer) |
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| 37   | RP: specialist (level 1 and 2) rehabilitation  
|      | • summary of UKROC/specialist commissioning requirements |
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RP: multidisciplinary team standards

From the time of onset, every patient should have access to a specialist multi-disciplinary rehabilitation team that:

- fulfills the criteria given below
- meets the needs of the patient with the required level of specialisation
- meets their needs with the required amount of input

A reasonable set of criteria to identify a specialist multi-disciplinary team that is of a suitable minimal standard would be that it:

9) is composed of staff who have specialized knowledge and skills in rehabilitation appropriate to the patients seen (initially acute trauma, but later on in the specialist group)

10) contains as members of the team all the professions needed to resolve at least 80% of the problems met.

11) should usually include as a minimum staff with certified specialist training in rehabilitation of the specific patient group from the following professions:

   a) doctors
   b) nurses
   c) physiotherapists
   d) occupational therapists
   e) clinical psychologists
   f) speech and language and/or other specific therapists (including teachers for children)
   g) social workers

12) is managed and funded as a single group of staff

13) has a single geographic base for all team members to use

14) has regular meetings as a group to discuss

   a) individual patients, usually weekly and at goal setting meetings if needed
   b) team policies, training etc

15) works within an agreed common framework, the biopsychosocial model of illness

16) uses agreed protocols and procedures for common clinical problems, including working across professional boundaries and sharing assessments
<table>
<thead>
<tr>
<th><strong>Who - patient</strong></th>
<th>Every patient in hospital after trauma for more than 48 hours (no exceptions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When - timing</strong></td>
<td>This should be completed by 48 hours after the incident.</td>
</tr>
<tr>
<td><strong>Who - personnel</strong></td>
<td>This should be completed by a senior member of a multi-disciplinary rehabilitation team</td>
</tr>
</tbody>
</table>
| **What - content** | **demographics**  
  ▪ date of birth, gender, home address/post code, name/identity of contact person (e.g. family)  
  ▪ service data  
    ○ date/time of contact  
    ○ location at time of contact (hospital, ward)  
    ○ lead consultant/trauma team at the time  
    ○ rehabilitation consultant/team responsible  
  ▪ accident details  
    ○ date of injury  
    ○ nature of accident (describe)  
  ▪ classification of major injury type  
    ○ spinal injury, musculo-skeletal including limb loss, neurological, burns, other (e.g. chest/thorax)  
  ▪ injuries. A full list, to include  
    ○ all injuries  
    ○ any major treatments/operations  
    ○ any major complications or secondary injuries  
  ▪ pre-existing illnesses and their active treatments  
  ▪ clinical status: level of consciousness  
  ▪ immediate rehabilitation needs:  
    ○ any immediate treatment needs  
    ○ risks to be considered  
  ▪ planned next assessment  
    ○ if this is part of a full initial assessment, then within 7 days  
    ○ if initial assessment not done, then by 96 hours |
| **So what - output** | a copy should be sent to the Network  
  a copy should accompany the patient at each and every transfer of care including at discharge at the end of the patient’s pathway  
  At some point, not necessarily immediately, a copy should be given to:  
  ○ the patient  
  ○ the patient’s general practitioner |
### RP: initial assessment

<table>
<thead>
<tr>
<th><strong>Who - patient</strong></th>
<th>• Every patient in hospital after trauma for more than 48 hours (no exceptions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When - timing</strong></td>
<td>• This should be completed by 96 hours after the incident.</td>
</tr>
</tbody>
</table>
| **Who - personnel** | • compiled by at least two senior member of a multi-disciplinary rehabilitation team  
  • completed by or fully discussed with a consultant in rehabilitation medicine (or their designed deputy) before signing off |
| **What - content** | • pre-morbid background:  
  o housing – type and who lives there  
  o social support – family, friends etc  
  o vocational status - work/other vocational activities  
  o pre-existing diseases and their active management  
  • trauma needs:  
  o outline of any specific further treatments (surgery etc)  
  o outline of any specific cautions and management advice  
  • care and treatment needs:  
  o physiological care and support needs, covering all major domains (cardio-vascular, respiratory, nutrition, excretion)  
  ▪ especially identifying management of any actual or potential risk  
  o list of medications  
  ▪ with name, dose, reason, review date, any monitoring needed  
  o list of equipment and adaptations provided:  
  ▪ type, purpose, details  
  ▪ when, who and how to contact about any problems  
  • rehabilitation status.  
  o Always cover:  
  ▪ personal Activities of Daily Living (ADL), using the Barthel ADL index as the preferred tool  
  ▪ cognition, including a statement on the person’s general Mental Capacity to make Health and Welfare decisions (recognising that any actual decision is specific to a particular issue)  
  ▪ emotional state  
  o standard, recognised tools should be used wherever possible  
  o **For example** the Rehabilitation Complexity Scale - Extended Trauma version would be a reasonable tool to use  
  o a checklist should be used to ensure all other important domains are considered – see recommended list  
  • rehabilitation prognosis, patient expectations and patient priorities:  
  o outline of prognosis, and what patient/family have been told  
  o any known priorities expressed by the patient  
  o any known expectations or wishes of the patient, including advance
directives and other specified wishes

- rehabilitation goals and needs.
  - immediate/ongoing care needs, related to specified goals, including specifically.
    - equipment needed
    - direct care & support required to maintain safety and wellbeing.
  - immediate treatment needs, relating to specified goal, including actions by:
    - rehabilitation service
    - patient, and family if appropriate
  - longer-term assessment and treatment needs, if can be identified

- future rehabilitation plans
  - specific rehabilitation services that have been/need to be contacted
    - especially specialist Level 1 or 2 rehabilitation services (in which case also record NPDS, NIS and RCS-ET)
  - any decisions made in a best interests meeting
    - especially concerning resuscitation, but also other potential emergencies

- risks
  - consideration of safeguarding and vulnerability

- date of next review

So what – output

- a copy should be sent to Network coordinator
- a copy should accompany the patient at each and every transfer of care including at discharge at the end of the patient’s pathway
- At some point, not necessarily immediately, a copy should be given to the patient and/or their representative or family if appropriate
- a copy, suitably updated, should accompany the patient at each transfer and at discharge
## RP: rehabilitation status

**Who – patient**
- Every patient still receiving or needing rehabilitation after trauma (i.e. not yet formally discharged)

**When – timing**
- This should be completed whenever the patient:
  - Moves from one service to another, **and**
  - If the patient needs a review within a service (this is defined later)

**Who – personnel**
- completed by at least two senior member of a multi-disciplinary rehabilitation team
- discussed with a consultant in rehabilitation medicine (or their designated deputy) before signing off

**What – content**
- Describe any major events or new information since the last RP: rehabilitation status
- Always describe present state of:
  - personal Activities of Daily Living (ADL), using the Barthel ADL index as the preferred tool
  - cognition, including a statement on the person’s general Mental Capacity to make Health and Welfare decisions (recognising that any actual decision is specific to a particular issue)
  - emotional state
  - any disabilities (activity limitations) mentioned in last report
  - any risks mentioned in last report
  - any impairments mentioned in last report
- a checklist should be used to ensure all other important domains are considered
  - any further domains identified as being limited should be described
- standard, recognised tools should be used wherever possible
  - **For example**, the Rehabilitation Complexity Scale - Extended Trauma version would be a reasonable tool to use
- a comment on existing risks should be given
  - clinical risks (e.g. seizures, skin, contractures etc)
  - social risks (e.g. safeguarding and vulnerability)
- give the date of next expected or recommended review

**So what – output**
- a copy should be given to the patient and/or their representative
- a copy should be sent to the GP
- a copy should be sent to network coordinator
## RP: Rehabilitation needs

<table>
<thead>
<tr>
<th>Who – patient</th>
<th>Every patient still receiving or needing rehabilitation after trauma (i.e. not yet formally discharged)</th>
</tr>
</thead>
</table>
| When – timing | This should be completed whenever the patient:  
  o Moves from one service to another, **and**  
  o If the patient needs a review within a service (this is defined later) |
| Who – personnel | completed by at least two senior member of a multi-disciplinary rehabilitation team  
  discussed with a consultant in rehabilitation medicine (or an appropriate other consultant with specialist experience and competence in rehabilitation) before signing off |
| What – content | a record of any active needs concerning injuries or other diseases  
  o reference to earlier RP documents with comment ‘no change’ is satisfactory  
  rehabilitation prognosis, patient expectations and patient priorities:  
  o outline of prognosis, and what patient/family have been told  
  o any known priorities expressed by the patient  
  o any known expectations or wishes of the patient  
  rehabilitation goals and needs.  
  o immediate/ongoing care needs, related to specified goals, including specifically.  
    ▪ equipment needed  
    ▪ direct care & support is required to maintain safety and wellbeing.  
  o immediate treatment needs, relating to specified goal, including actions by:  
    ▪ rehabilitation service  
    ▪ patient, and family if appropriate  
  o longer-term assessment and treatment needs  
    ▪ related to longer-term goals  
  o anticipated time until (or date of):  
    ▪ transfer to another specified service and/or  
    ▪ discharge from rehabilitation  
  future rehabilitation plans  
  o specific services that have been/need to be contacted  
    ▪ other rehabilitation services (of any sort)  
    ▪ vocational/educational services  
    ▪ social services, care services etc  
    ▪ voluntary organisations  
  o any decisions made in a best interests meeting  
    ▪ especially concerning resuscitation, but also other potential decisions |
| So what – output | The **receiving** service (or current service, if part of a time-based review) |
should for each and every identified need (action) indicate:
  o If the need is accepted clinically as valid:
    ▪ If the need is not agreed, a justification and reason must be given
  o
  • a copy should be given to the patient and/or their representative
  • a copy should be sent to the GP
  • a copy should be sent to Network coordinator
### RP: transfer

**Who – patient**

- Every patient in healthcare system after trauma

**When – timing**

- This should be completed whenever the patient is moved from one service or team to another, whether or not they are also moving between organisations or to a different location

**Who – personnel**

- completed by at least one senior member of the surgical/medical team responsible and/or one senior member of the multi-disciplinary rehabilitation team

**What – content**

- **service data**
  - date of prescription
  - location at time of prescription (hospital/ward)
  - transferring service: names and contact details for
    - team responsible for trauma management
    - team responsible for rehabilitation
    - rehabilitation network coordinator
  - transfer destination:
    - location (hospital/ward; other)
    - rehabilitation service and named contact (or rehabilitation input not needed)
    - trauma service and named contact (or trauma service not needed)
    - actual date of transfer

- **care and treatment needs:**
  - physiological care and support needs, covering all major domains (cardio-vascular, respiratory, nutrition, excretion)
    - especially identifying management of any actual or potential risk
  - list of medications
    - with name, dose, reason, review date, any monitoring needed
  - list of equipment and adaptations provided:
    - type, purpose, details
    - when, who and how to contact about any problems
  - trauma service follow-up
    - any immediate needs or precautions for next service to continue
    - including any management planned by trauma service
  - rehabilitation service follow-up (if any) and
    - any referrals made to other rehabilitation services, and current status of referral

- **Information/expectations**
  - what outcome is expected (range, at a given time)
- The receiving service should feedback if information is missing
- A copy should be sent to network coordinator
**RP: discharge**

<table>
<thead>
<tr>
<th><strong>Who - patient</strong></th>
<th>Every patient discharged from healthcare after trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When - timing</strong></td>
<td>This should be completed the patient has no planned further treatment or assessment contacts within the next six months</td>
</tr>
<tr>
<td><strong>Who - personnel</strong></td>
<td>completed by the multi-disciplinary rehabilitation team, including the consultant with rehabilitation training who must agree the discharge</td>
</tr>
</tbody>
</table>
| **What - content** | **service data**  
  - date of prescription  
  - location at time of prescription (hospital/ward)  
  - discharge service: names and contact details for  
    - team responsible for trauma management  
    - team responsible for rehabilitation  
    - rehabilitation network coordinator  
  - discharge situation:  
    - location (home, residential care, etc)  
  - list of other agencies with ongoing responsibility or involvement:  
    - name, support given, any discharge/review date  
    - when, who and how to contact about any difficulties  
  **care and support needs:**  
    - physiological care and support needs, covering all major domains (cardio-vascular, respiratory, nutrition, excretion)  
      - especially identifying management of any actual or potential risk  
    - list of medications  
      - with name, dose, reason, review date, any monitoring needed  
    - list of equipment and adaptations provided:  
      - type, purpose, details  
      - when, who and how to contact about any problems  
    - list of ongoing care/support needs concerning basic personal and domestic activities and participation in social and leisure activities  
  **Expectations**  
    - what complications/problems might arise |
| **So what - output** | A copy should be sent to network coordinator  
  A copy should be sent to all services previously involved  
  A copy should go to the General Practitioner  
  A copy should go to the patient  
  A copy should go to any services providing on-going support (e.g. Social Services, nursing home) |
### Implementing the Rehabilitation Prescription

**RP: specialist (Level 1 or 2) rehabilitation**

#### Who - patient
- Any patient thought on clinical grounds likely to need specialised rehabilitation after using the BSRM Patient Categorisation Screening Tool

#### When - timing
- As soon as the patient’s Category A or B status (i.e. needs level 1 or level 2 service, and eligible for Specialised Commissioning funding) has been confirmed by a Consultant in Rehabilitation Medicine

#### Who - personnel
- The multi-disciplinary rehabilitation team, including a consultant in Rehabilitation Medicine (a commissioning requirement)

#### What - content
- **Patient categorisation tool** (see UKROC dataset)
- **The Rehabilitation Complexity Scale – Trauma** (RCS E-Trauma)

If the patient is categorised as **Needs Category ‘A’ or ‘B’**, then further content is needed:
- Northwick Park Nursing Dependency Scale
- Rehabilitation Complexity Scale – Extended Trauma version (RCS-ET)
- Trauma Impairment Set data.

Once a patient is admitted the service will need to supply:
- Admission demographic data
- Rehabilitation Complexity Scale (v13) every two weeks
- UK Functional Assessment Measure (FIM/FAM) and Northwick Park nursing Dependency Scale (NPDS) on admission and discharge

#### So what - output
- The identified **need** for specialist rehabilitation should be recorded
- The Network Coordinator should be informed
- The delay between referral to level 1 or 2 centre and final admission should be documented (will be picked up by UKROC database)
RP: quality improvement

<table>
<thead>
<tr>
<th>Who - patient</th>
<th>• Every surviving patient admitted after trauma (no exceptions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When - timing</td>
<td>• Specified fixed time(s) after trauma, probably six months</td>
</tr>
<tr>
<td>Who - personnel</td>
<td>• Uncertain</td>
</tr>
<tr>
<td>How</td>
<td>• Uncertain; post, telephone, email, web, direct visit, text message</td>
</tr>
<tr>
<td>What - content</td>
<td>• background information, needed to interpret data, such as:</td>
</tr>
<tr>
<td></td>
<td>• pre-injury social situation (accommodation, work, family etc)</td>
</tr>
<tr>
<td></td>
<td>• injury category (neurological, spinal, musculo-skeletal, other)</td>
</tr>
<tr>
<td></td>
<td>• pre-morbid EQ5D (by recall); national item</td>
</tr>
<tr>
<td></td>
<td>• ISS score in some instances</td>
</tr>
<tr>
<td></td>
<td>• Specific injury details, if a specific subgroup is being monitored</td>
</tr>
<tr>
<td></td>
<td>• Early measures of severity (data collected at 1-2 weeks):</td>
</tr>
<tr>
<td></td>
<td>• Barthel ADL index score (Wade and Collin version 1988)</td>
</tr>
<tr>
<td></td>
<td>• EQ5D; national item</td>
</tr>
<tr>
<td></td>
<td>• Process measures:</td>
</tr>
<tr>
<td></td>
<td>• Needs identified but not met, recording for each</td>
</tr>
<tr>
<td></td>
<td>• the need</td>
</tr>
<tr>
<td></td>
<td>• degree not met (not at all, some but below level)</td>
</tr>
<tr>
<td></td>
<td>• reason not met (e.g. not available at all; inadequate level available)</td>
</tr>
<tr>
<td></td>
<td>• action taken (e.g. none, referred on, bought in service)</td>
</tr>
<tr>
<td></td>
<td>• Delays in transfer</td>
</tr>
<tr>
<td></td>
<td>• nature (from where to where)</td>
</tr>
<tr>
<td></td>
<td>• reason</td>
</tr>
<tr>
<td></td>
<td>• Timing of events</td>
</tr>
<tr>
<td></td>
<td>• dates of transfers etc</td>
</tr>
<tr>
<td></td>
<td>• Discharge status (of doubtful utility, but sometimes helpful)</td>
</tr>
<tr>
<td></td>
<td>• EQ5D; national item</td>
</tr>
<tr>
<td></td>
<td>• Outcome measures:</td>
</tr>
<tr>
<td></td>
<td>• patient experience</td>
</tr>
<tr>
<td></td>
<td>• patient function and social outcome</td>
</tr>
<tr>
<td></td>
<td>• EQ5D, GOSE; national items</td>
</tr>
<tr>
<td></td>
<td>• specific items (e.g. returned to previous accommodation, work)</td>
</tr>
<tr>
<td></td>
<td>• adverse events:</td>
</tr>
<tr>
<td></td>
<td>• skin pressure ulceration, further injury</td>
</tr>
<tr>
<td>So what - output</td>
<td>• Comparison over time and between services</td>
</tr>
<tr>
<td></td>
<td>• identification of service deficiencies</td>
</tr>
<tr>
<td></td>
<td>• Identification of adverse outcomes</td>
</tr>
</tbody>
</table>
RP: Check-list

This is a check-list to consider at any review point including within first four days. It is intended to be an aide-memoire. If the answer is no, no action is needed but if the answer is ‘yes’, then something more should be asked and something should be documented in the patient record and appropriate rehabilitation prescription.

**Impairment** (patient experience, symptoms and signs)
Is there any evidence that the patient is experiencing or has:
- pain (even if well controlled now)
- emotional distress or problems
- disturbance of motor control and active range of movement at all joints
- disturbance of somatic (bodily) sensation
- disturbance of vision and eyesight
- disturbance of ears and hearing
- any change in normal memory, concentration, and thinking
- any difficulty with speech and communication
- any problems with chewing or swallowing
- any problems with bladder or bowel control
- any changes in style and content of social interaction
- any change in noticing and responding to risk and danger

**Activities** (functional tasks, disability)
Has the patient returned to their normal (pre-accident) level of function in terms of:
- mobility, getting from the bed to wherever they wish to go
- dexterity, the use of their arms
- personal activities of daily living – dressing, grooming, toileting, washing
- domestic activities – looking after themselves at home – cooking, housework
- community activities – shopping, getting around,
- vocational activities – work, education, voluntary work
- leisure activities
- social activities
### Audit data to collect on TARN

**First, admission service**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>No, but ..</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 48 hours after trauma, was there:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An entry from a senior member of a named specialist rehabilitation service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A list of all the injuries sustained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A statement about immediate rehabilitation needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By 72 hours after trauma was there:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An entry in the notes from a consultant in Rehabilitation Medicine (or their designated deputy)</td>
<td></td>
<td></td>
<td>• entry from specialist registrar</td>
</tr>
<tr>
<td>• patient transferred out and definite planned contact documented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By 96 hours after trauma was there:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An assessment from at least two senior members of a full multidisciplinary rehabilitation team?</td>
<td></td>
<td></td>
<td>• two senior therapists, not part of a team</td>
</tr>
<tr>
<td>An assessment (or clinical opinion) by a Consultant in Rehabilitation Medicine or a designated deputy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A record of personal Activities of Daily Living recorded using the Barthel ADL index</td>
<td></td>
<td></td>
<td>• An approved alternative standard measure used (e.g. FIM or NPDS)</td>
</tr>
<tr>
<td>Documentation of cognitive function (including coma)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of emotional state</td>
<td></td>
<td></td>
<td>• Patient unaware or unresponsive</td>
</tr>
<tr>
<td>At transfer of care from <strong>first</strong> service:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the receiving service named, together with a named person in that service?</td>
<td></td>
<td></td>
<td>• Patient discharged from rehabilitation</td>
</tr>
<tr>
<td>Was a list of rehabilitation needs transferred with patient?</td>
<td></td>
<td></td>
<td>• Patient discharged from rehabilitation</td>
</tr>
<tr>
<td>Was there an indication of rehabilitation (disability) prognosis and/or potential complications?</td>
<td></td>
<td></td>
<td>• Patient discharged from rehabilitation</td>
</tr>
</tbody>
</table>
Audit data to collect on TARN

Each service involved after 5 days or first transfer

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>No, but ..</th>
</tr>
</thead>
</table>

### On arrival in your service:

- **Did you receive a statement of rehabilitation needs?**
  - Already in service

- **Could you meet over 80% of the needs identified?**
  - Already in service

- **Did you receive a list of original injuries?**
  - Already in service

### While in your service:

- **Was there a documented rehabilitation review (RP: status & RP: needs) every week (first six weeks) or every four weeks?**

- **Was the patient fully assessed by a consultant in Rehabilitation Medicine or their designated deputy?**
  - Seen by all bar one

- **Was the patient seen, assessed and treated by all the different professions needed?**
  - Received 85% as measured by the RCS-ET

- **Did the patient receive the level of therapy input identified as necessary at all times?**
  - Seen by all bar one

### When transferred out from your service was there:

- **A documented assessment by at least two senior members of a full multidisciplinary rehabilitation team?**
  - Two senior therapists, not part of a team

- **A record of personal Activities of Daily Living recorded using the Barthel ADL index**
  - An alternative approved standard measure used (e.g. FIM or NPDS)
  - Not an inpatient hospital service

- **Documentation of cognitive function (including coma)**

- **Documentation of emotional state**
  - Patient unaware or unresponsive

- **Documentation of rehabilitation needs based on a full multi-disciplinary rehabilitation team review?**

- **Did you transfer all required documents to the next service (or GP if discharged) with the patient?**
Audit data to collect on TARN
Discharge

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>No, but ..</th>
</tr>
</thead>
<tbody>
<tr>
<td>When discharging the patient from rehabilitation, did you:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Produce a statement that there were no further rehabilitation needs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document level of personal Activities of Daily Living</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document level of Domestic ADL?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document level of mobility?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document level of emotional distress?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document specific complications to be aware of?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify who to contact, how and when in relation to rehabilitation needs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify the relevant trauma specialist service(s) involved?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify ongoing care and drug treatment needs?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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