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# Piloting the Stratification of a Geriatric Intermediate Bed-Based Rehabilitation Service

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## Overview of the Rehabilitation and "Discharge to Assess" Pathway 2 services within the NHS

Rehabilitation is defined as "a process of assessment, treatment and management by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living. Patient goals for rehabilitation vary according to the trajectory and stage of their condition.". (British Society of Rehabilitation Medicine, 2019)

Following an acute hospital admission, there are various discharge pathways supported by the NHS, under the Discharge to Assess model (Appendix 1)(NHS England, 2015). Pathway 2 within the Discharge to Assess model, is the transfer of a patient from Acute Hospital to Intermediate care-including Bed-Based Rehabilitation (BBICT) and Specialist Rehabilitation services (NHS England, 2015) . The National Institute of Clinical Excellence (NICE) outlines BBICT as a service that provides assessment and interventions in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks and are provided by a multidisciplinary team (NICE, 2017).



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**Mary Seacole Ward, Queen Mary's Hospital**

Mary Seacole Ward is a Geriatric bed-based rehabilitation service based at Queen Mary's Hospital in southwest London, as part of St. George's University Hospitals NHS Foundation Trust. The Unit has 42-beds, consisting of 6 single-sex 6-bed bays and 6 single side rooms, with access to a therapy gym and equipment outside of the ward setting. A team of nurses, health care assistants, physiotherapists, occupational therapists, therapy assistants, speech and language therapists, dieticians, pharmacists, doctors, social workers and volunteers work in partnership, to support patients to improve their ability to care for themselves, after an acute hospital stay. Following a short-term admission for inpatient rehabilitation on Mary Seacole Ward, patients can continue their rehabilitation under the community services, depending on their ongoing rehabilitation goals. (St Georges University NHS Foundation Trust, 2013).

Mary Seacole Ward is commissioned to provide a minimum of 3 therapy contacts a week with any therapy discipline, 24-hour nursing care and 1 medical contact a week with a Consultant Geriatrician, including a Complex Geriatric Assessment on admission. In addition to rehabilitation, the Unit can provide ward-level medical care with access to oxygen therapy, intravenous fluids and intravenous medications, radiological investigations, if required. Resident doctors are present 9am-8pm on weekdays and 9am-5pm on weekends to provide medical input, with care overseen by the Consultant Geriatrician. As the Unit does not provide 24h on-site medical presence, nor level 2 monitoring, patients at acute risk of deterioration or in need of 24h medical input, may be transferred to the acute hospital, if this is within the patient's escalation plan.

**Stratification of UK Rehabilitation Services**

The current stratification of the Pathway 2 services was developed during the COVID-19 Pandemic, according to the needs and complexity of patients within the services (NHS England, 2022)

Figure 1: Criteria to reside categories within Pathway 2 services (NHS England, 2022)

The UK Rehabilitation services are also classified as outlined by the (British Society of Rehabilitation Medicine, 2019) and (Appendix 5, NHS Commissioning Board, 2013) Figure 2:



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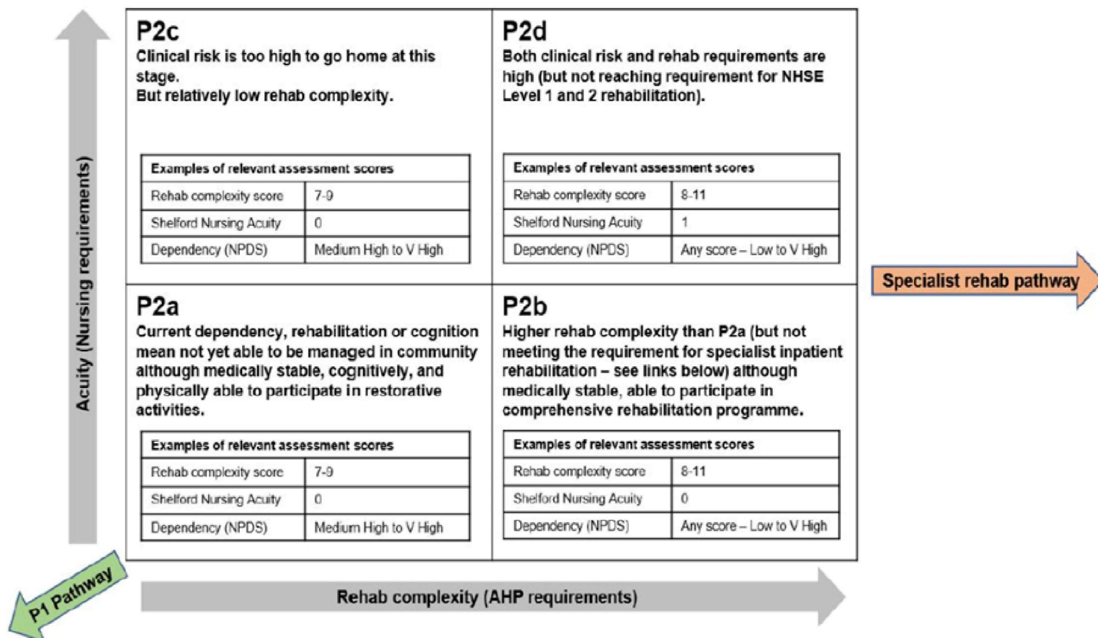


Figure 1

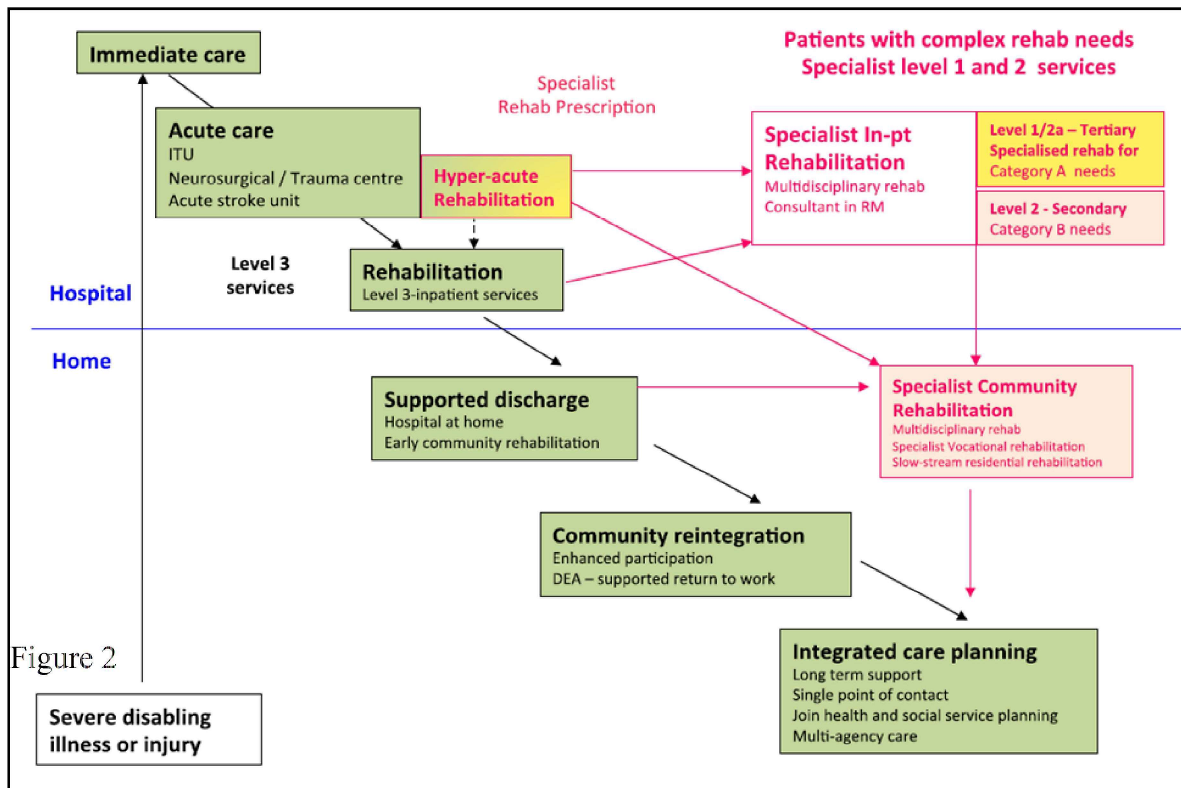


Figure 2

Figure 2



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- UKROC Criteria: ³70% of patients with RCS scores ³11 cross-sectionally; ³85% patients with Category A needs on admission.

Level 1: Tertiary 'specialised' rehabilitation services

- High cost / low volume services, which provide for patients with highly complex rehabilitation needs that are beyond the scope of their local and district specialist services.

Level 2: Local (district) specialist rehabilitation services

- Led or supported by a consultant trained and accredited in Rehabilitation medicine (RM), working both in hospital and the community setting.
- UKROC Criteria: Level 2a :50-70% of patients with RCS scores ³11 cross-sectionally; 50-80% patients with Category A needs on admission; Level 2b: 30-50% of patients with RCS scores ³11 cross-sectionally and Category A needs on admission

Level 3: Local non-specialist rehabilitation

- Teams provide general multi-professional rehabilitation and therapy support for a range of conditions within the context of acute services (including stroke units), intermediate care or community services.

Hyper-acute Specialist Rehabilitation services

- Sited within acute care settings, when patients still have medical and surgical needs requiring continued active support from the trauma, neuroscience or acute medical services.

(British Society of Rehabilitation Medicine, 2019) ; (NHS Commissioning Board, 2013)

Stratification of patient groups is widely used within Level 1 and 2 specialist rehabilitation services, via the UKROC database, to both ensure the units are meeting the needs of their cohort and support the ongoing challenges between outcomes and cost-effectiveness. (Lynne Turner-Stokes, 2012) . (British Society of Rehabilitation Medicine, 2019) . The UKROC database collates data on needs, inputs and outcomes for all patients admitted to inpatient specialist rehabilitation services in England, using the Rehabilitation Complexity Scale (Appendix 2) and The Northwick Park nursing and therapy dependency tools (Appendix 4); in addition, it provides quarterly benchmarking reports on quality and cost–efficiency, comparing the



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performance of each service with its peer group on key quality (British Society of Rehabilitation Medicine, 2019).

The Pathway 2 Model (figure 1), uses the Rehabilitation complexity scale (appendix 2), Northwick Park dependency scale (appendix 4) and the Shelford Safer Care Nursing tool (appendix 3) to stratify patient acuity and complexity. The Rehabilitation complexity scale (RCS) measures the complexity of needs for rehabilitation resources in terms of nursing care, medical support therapies, and specialist equipment (British Society of Rehabilitation Medicine, 2019). The Northwick Park Dependency Scale (NPDS) "provides an assessment of care and nursing needs in rehabilitation setting, which translates directly into an assessment of care hours and costs of providing care in the community" (Turner-Stokes). The Shelford Safer Nursing Care tool is used to measure patient acuity and/or dependency to inform optimum nursing staffing levels (NHS England, 2023).

This Pilot aims to apply existing stratification models to establish the service level provided at Mary Seacole Ward, in line with the NHS England Pathway 2 stratification model and to discuss the potential for using complexity stratification within the Level 3 and Geriatric Rehabilitation services, to support adequate service provision.

**Methods**

Stratification of the patient cohort on Mary Seacole Ward was Piloted for all inpatients during the month of September 2022.

The Rehabilitation Complexity Scale (RCS, Appendix 2) scoring model was used to quantify Patients':

- Basic care and support needs [C0-4];
- Risk: Cognitive/Behavioural needs [R0-4];
- Skilled nursing needs [N0-4];
- Medical needs [M0-4];
- Therapy needs: Number of disciplines [TD0-4], Therapy intensity [TI0-4]
- Equipment needs [E0-2].

The RCS has a minimum score of 0 and a maximum score of 26.

The Shelford Group Safer Nursing Care Tool, 2013 (Appendix 3) was used to stratify the medical stability and dependence of patients on the Unit, ranging from:

- Level 0: Needs met by normal ward cares


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- Level 1a: Acutely ill requiring intervention or unstable with a greater potential to deteriorate
- Level 1b: Stable but dependent on nursing care for most/all activities of daily living
- Level 2: May be managed within clearly designated beds with specific expertise
- Level 3: Needing advanced respiratory support +/- support of multiple organs

The Shelford Levels are collated each shift by the Nurse in Charge as standard practice, the data for the day shift of each MDT meeting was extrapolated from the Unit's existing records. The NHS also acknowledges the Northwick Park Dependency Score (appendix 4) to support stratification of patients in the different pathways of care, this was not collected as part of the stratification pilot on Mary Seacole Ward. A total of 101 RCS scores were collected over a period of 5 MDT meetings across 3 weeks.

**Data Collection**

Rehabilitation Complexity Scale (RCS) scores were collected for each inpatient on Mary Seacole Ward during the weekly multidisciplinary team (MDT) meetings for each half of the Unit, during September 2022, with each discipline providing scores for their respective category. In Week 1, data was only collected for the first half of the Unit. In Week 2 and Week 3 data was collected for both halves of the Unit at their respective MDT meetings. The RCS scores were recorded manually on printed copies of the version 13 proforma (Appendix 2) and filled out by the consultant leading the MDT meeting, these scores were then transcribed onto an excel spreadsheet for analysis.

**Data Analysis**

The Rehabilitation Complexity Scores (RCS) were recorded and analysed within the functions of Microsoft Excel. The scores were averaged as a total score and as the specialty components of the RCS (C, R, N, M, TD, TI, E) to explore the complexity of input needed in each category. The distribution of the number of patients with a respective RCS score was also outlined for each week.

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| RCS | C | R | N | M | TD | TI | E | Total | Min Score | Max Score |
|---|---|---|---|---|---|---|---|---|---|---|
| **Week 1 (N=21)** | 1.3 | 0.9 | 1.0 | 0.8 | 2.3 | 2.1 | 1.0 | 9.4 | 6 | 13 |
| **Week 2 (N=39)** | 1.4 | 0.5 | 1.0 | 0.7 | 2.2 | 1.8 | 1.1 | 8.5 | 4 | 13 |
| **Week 3 (N=41)** | 1.4 | 0.5 | 1.0 | 1.0 | 2.2 | 2.1 | 1.0 | 9.3 | 6 | 14 |

Chart 1: Total RCS scores distribution across all weeks of data collection

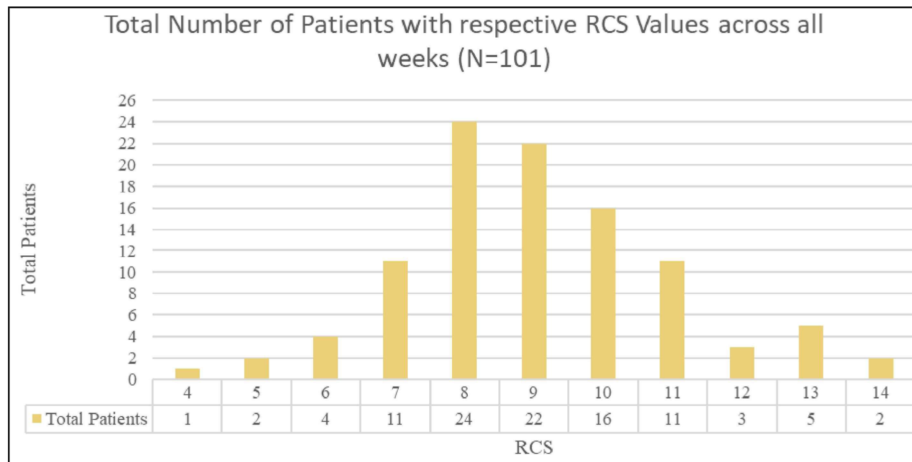
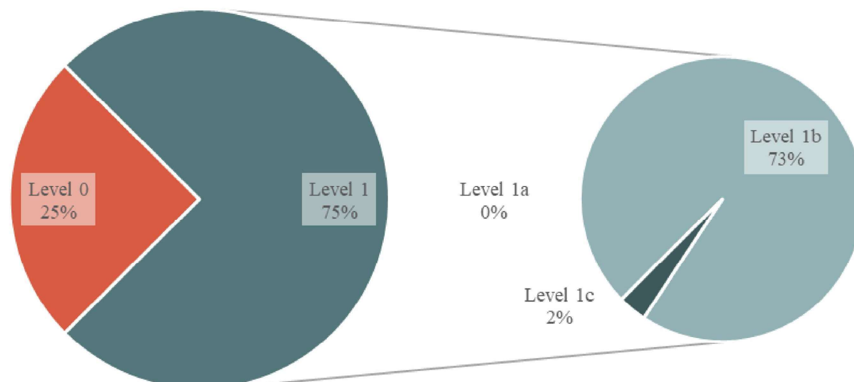



Chart 2: Distribution of Inpatient Shelford Levels for the day shift of RCS data



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**Discussion**

Using the (British Society of Rehabilitation Medicine, 2019) classification, Mary Seacole Ward meets the criteria of a non-specialised, Level 3 Rehabilitation Service, however, prior to this pilot, the service's classification within the Criteria to Reside Pathway 2 stratification (Figure 1, (NHS England, 2022) , was unclear.

Throughout the period of data collection, the cohort's RCS scores (N=101) range from 4-14. The average RCS score over the total 3 weeks was 8.7 (Chart 1). The Distribution of Shelford Nursing Scores across the 5 data collection days over 3 weeks are demonstrated in Chart 2, highlighting 75% of our patients had a Shelford Score of 1 on the days of data collection.

Using the Criteria to Reside pathway 2 stratification (Figure 1), 37% of patients had an RCS score $^{3}$10, solely meeting the P2b or P2d criteria, depending on their Shelford nursing scores. 75% of our patients had a Shelford score of 1, exclusively meeting P2d criteria (provided their RCS score was also $^{3}$8). 6.9% of patients had an RCS <7, below the complexity recommended for the pathway 2 services. We do not have the data to correlate each patients' RCS with their Shelford nursing score to generate the absolute numbers meeting each Criteria to Reside Pathway 2 categories, nor do we have the NPDS to support the differentiation between P2a/c with P2b/d. Within the limitations of our pilot, we can infer that most of our patients meet the P2d criteria: "Both clinical risk and rehab requirements are high (but not reaching requirement of NHSE Level 1 and 2 Rehabilitation)", due to the predominance of patients requiring Shelford level 1 nursing care.

Using the criteria outlined for the Specialist rehabilitation services (NHS Commissioning Board, 2013) , 20.8% of patients had an RCS score of $^{3}$11, with the recommendation for the lower tier of specialised rehabilitation service (level 2b) criteria being 30-50% of patients with an RCS score $^{3}$11 cross-sectionally, confirming the unit as a Level 3 service, however the full criteria for a Level 3 service is not as clearly defined.

Currently, Mary Seacole Ward uses the length of stay and number of readmissions to acute hospital as outcome measures, however this does not reflect the medical and rehabilitation complexity of the patient



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cohort, nor provides outcome measures to assess progress in rehabilitation.

The specialist rehabilitation services use the UKROC database to stratify their cohort complexity and monitor their outcomes to review the quality and cost effectiveness of each service to support funding and commissioning (British Society of Rehabilitation Medicine, 2019) . This data will have supported the clearly outlined criteria, minimum staffing provisions and quality standards, as outlined in the NHS contract for Level 1 and 2 specialised rehabilitation services (NHS Commissioning Board, 2013) . The Non-specialised Level 3 Rehabilitation services could benefit from using a similar model, to support clear service standards and commissioning.

The service standards outlined for the specialist rehabilitation services are designed to meet the needs of patients, of all ages, with complex disability (NHS Commissioning Board, 2013) . It is worth considering whether the Geriatric Rehabilitation services would benefit from a stratification tailored to adults living with frailty, it is unclear if the stratifications used by the specialist rehabilitation services would appropriately support this.

**Conclusion**

Collecting data on patients' complexity, needs and measurable outcomes can support the development of appropriate service standards and commissioning for a rehabilitation service, to ensure services are meeting the needs of their cohorts, as well as demonstrating cost-effectiveness (British Society of Rehabilitation Medicine, 2019) (Lynne Turner-Stokes, 2012). The level 3 rehabilitation services are not routinely required to measure the complexity of their patient cohorts in the same way as the specialised rehabilitation services.

This pilot has trialed the stratification of rehabilitation complexity for the patient cohort of Mary Seacole ward, a level 3 rehabilitation service, using the Pathway 2 model (figure 1) (NHS England, 2022). Within the limitations of this pilot, we have established the complexity of our cohort mostly meets the P2d classification of the Pathway 2 services (NHS England, 2022). Following this pilot, we would suggest trialing stratification, over a longer period and including the Northwick Park Dependency Score, to evaluate the service within the current outline of the UK Pathway 2, non-specialised rehabilitation services. With further studies, we would



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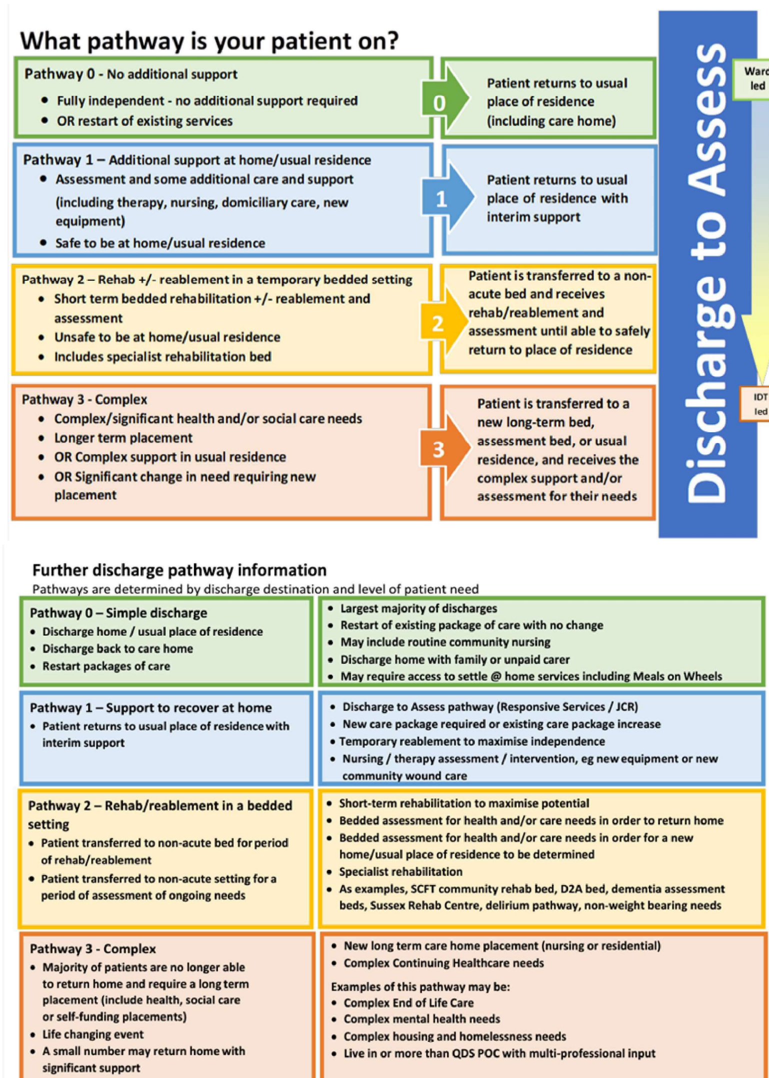
aim to explore the role of stratification, to better understand the variety and needs of the level 3 rehabilitation services in the UK, to support improved outcomes and appropriate commissioning of non-specialised and Geriatric rehabilitation services.

## Appendix

Appendix 1: Hospital Discharge Pathways 0, 1, 2, 3 Graphic (**University Hospitals Sussex NHS Foundation Trust, 2020)**



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Appendix 2: Rehabilitation Complexity Score; RCS Version 13. Prof Lynne Turner-Stokes 05.04.2012

*RCS Version 13. Prof Lynne Turner-Stokes 05.04.2012*

# The Rehabilitation Complexity Scale: extended (version 13)

## *Further instructions for application*

**For each subscale, circle highest level applicable**

**CARE or RISK**
Describes the level of support the patient needs for either basic self care or to maintain their safety

**NB: If not sure which to record, rate both CARE and RISK and use highest score**

**BASIC CARE AND SUPPORT NEEDS**

Includes assistance for basic care activities (either physical help or stand0by supervision)
Includes washing, dressing, hygiene, toileting, feeding and nutrition, maintaining safety etc.

| | |
|---|---|
| **C 0** | **Largely independent**. Manages basic self-care tasks largely by themselves.<br>May have incidental help just to set up or to complete – e.g. application of orthoses, tying laces etc |
| **C 1** | Requires **help from 1 person** for most basic care needs ie for washing, dressing, toileting etc.<br>May have incidental help from a 2nd person – e.g. just for one task such as bathing |
| **C 2** | Requires **help from 2 people** for the majority of their basic care needs |
| **C 3** | Requires **help from ≥3 people** for basic care needs |
| **C 4** | Requires constant **1:1 supervision** e.g. to manage confusion and maintain their safety |

**RISK- COGNITIVE / BEHAVIOURAL NEEDS**

(An alternative care primarily for 'walking wounded' patients who may be able to manage all/most of their own basic care, but there is some risk for safety eg due to confusion, impulsive behaviour or neuropsychiatric disturbance )
Includes supervision to maintaining safety or managing confusion eg in patients to have a tendency to wander, or managing psychiatric / mental health needs.

| | |
|---|---|
| **R 0** | **No risk – Able to maintain their own safety** and **to go out unescorted**<br>Able to maintain their own safety at all times |
| **R 1** | **Low risk –** standard precautions only for safety monitoring within a structured environment<br>But **requires escorting** outside the unit<br>Maintains own safety within a structured environment, requiring only routine checks, but requires accompanying when outside the unit |
| **R 2** | **Medium risk – additional safety measures** OR managed under MHA section<br>Additional safety measures even within a structured environment, eg alarms, tagging, or above standard monitoring (eg 1-2 hrly checks)<br>OR managed under section of the Mental Health Act (time for additional paperwork etc) |
| **R 3** | **High risk –Frequent observations** (May also be managed under MHA section)<br>Needs frequent observations even within a structured environment, eg ½ -1 hrly checks, or 1:1 supervision for part(s) of the day/night |
| **R 4** | **Very high risk -** Requires **constant 1:1 supervision**<br>Needs 1:1 supervision all of the time |


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| **SKILLED NURSING NEEDS**<br>Describes the level of skilled nursing intervention form a qualified or specialist trained nurse | | |
|---|---|---|
| **N 0** | No needs for skilled nursing – needs can be met by care assistants only | **Tick nursing disciplines required:** |
| **N 1** | Requires intervention from a **qualified nurse** (with general nursing skills and experience)<br>e.g. medication, wound/stoma care, nursing obs, enteral feeding, setting up IV infusion etc) | General registered nursing<br>Rehab-trained nurses<br>Mental Health (RMN) |
| **N 2** | Requires intervention from **nursing staff who are trained and experienced in rehabilitation**<br>e.g. for maintaining positioning programme, walking / standing practice, splint application, psychological support | Palliative care nursing |
| **N 3** | Requires **highly specialist nursing care** e.g. for very complex needs such as<br>• Management of tracheostomy Management of challenging behaviour / psychosis / complex psychological needs<br>• Highly complex postural, cognitive or communication needs<br>• Vegetative or minimally responsive states, locked-in syndromes | Specialist neuro nurse (eg MS, PD, MND)<br>Other |
| **N 4** | Requires **high dependency specialist nursing** (high level nursing skills and intensive input)<br>eg medically unstable, requiring very frequent monitoring/ intervention by a qualified nurse - hourly or more often, (usually also specialist training eg IV drug administration or ventilation etc). | |

| **MEDICAL NEEDS**<br>Describes the approximate level of medical care environment for medical/surgical management | | |
|---|---|---|
| **M 0** | **No active medical intervention** - Could be managed by GP on basis of occasional visits) | **Tick medical interventions required:** |
| **M 1** | **Basic investigation / monitoring / treatment**<br>(Requiring non-acute hospital care, could be delivered in a community hospital with day time medical cover)<br>i.e. requires only routine blood tests / imaging. Medical monitoring can be managed through review by a junior medic x2-3 per week, with routine consultant ward-round + telephone advice if needed) | Blood tests<br>Imaging (CT / MRI)<br>Other Investigation<br>State type.......................... |
| **M 2** | **Specialist medical / psychiatric intervention - for diagnosis or management/procedures**<br>(Requiring in-patient hospital care in DGH or specialist hospital setting)<br>i.e. requires more complex investigations, or specialist medical facilities e.g. dialysis, ventilatory support. Frequent or unpredictable needs for consultant input or specialist medical advice, surgical intervention , psychiatric evaluation/treatment. | Medication adjustment / monitoring<br>Surgical procedure (eg tenotomy)<br>State type.......................... |
| **M 3** | **Potentially unstable medical / psychiatric condition** - Requiring 24 hour on-site acute medical / psychiatric cover (depending on type of need)<br>Potentially unstable: May require out-of hours intervention – e.g. for uncontrolled seizures, immuno-compromised condition, - or for psychiatric medical adjustment / emergency risk assessment etc)<br>Needs to be managed in a setting where there is on-site 24 emergency medical /psychiatric cover. | Medical procedure (eg Botulinum toxin)<br>State type...................................<br>Specialist opinion<br>State discipline.............. |
| **M 4** | **Acute medical / surgical problem (or psychiatric crisis)** Requiring emergency out-of-hours, intervention<br>Requires acute medical/surgical care e.g. infection, acute complication, post surgical care. Ie actual involvement of the 24 hour medical (or surgical or psychiatric) services, whether on a planned or unplanned basis | Medico-legal or capacity issues<br>Other................. |



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**THERAPY NEEDS**

Describes the
a) number of different therapy disciplines required and
b) intensity of treatment

Includes individual or group-based session runs by therapists, but NOT rehabilitation input from nursing staff which is counted in N2.

(NB The Northwick Park Therapy Dependency Assessment (NPTDA) can be used to calculate total therapy hours in more complex cases e.g. and provide more detailed information regarding time for each discipline etc. It also includes quantitative information on the rehabilitation time provided by nursing staff)

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

| Code | Description |
|---|---|
| **TD 0** | **0** – no therapist involvement |
| **TD 1** | **1** discipline only |
| **TD 2** | **2-3** disciplines |
| **TD 3** | **4-5** disciplines |
| **TD 4** | **≥6** disciplines |

**Tick therapy disciplines required:**

| | | |
|---|---|---|
| Physio | Psychology | Orthotics |
| O/T | Counselling | Prosthetics |
| SLT | Music/art therapy | Rehab Engineer |
| Dietetics | Play therapy/school | Other: |
| Social work | DEA/Jobcentre Plus | |
| Other | Recreational therapy | |
| | Other | |

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

| Code | Description |
|---|---|
| **TI 0** | **No therapy intervention**<br>(Or a total of <1 hour therapy input per week - Rehab needs are met by nursing/care staff or self-exercise programme) |
| **TI 1** | Low level – **less than daily** (eg assessment / review / maintenance / supervision)<br>OR **Group therapy sessions only**<br>(ie Patient does not receive therapy sessions every day ( or has <1 hour therapy per day)<br>This usually means that a) they currently have mainly needs for care, nursing or medical treatment, or b) they are on a low intensity review only or group-based programme – or c) they are on a winding-down programme in preparation for discharge) |
| **TI 2** | Moderate – **daily intervention - individual sessions with one therapist** to treat for most sessions<br>OR **very intensive Group programme** of ≥6 hours/day<br>(ie Patient may have treatment from a number of different therapists (see TD), but is treated by one therapist at a time<br>They will normally have therapy sessions every day 5 days a week, for a total of 2-3 hours per day (some of which may be periods of self-exercise under distant supervision if they are able)<br>Or they have therapy in group based sessions on a very intensive basis (> 6 hours per day spent in group sessions) |
| **TI 3** | **High level – Daily intervention with therapist PLUS assistant and/or additional group sessions**<br>Patient requires a second pair of hands for some treatment sessions, treatments ( eg physical handling) and so is treated by a therapist with an assistant ( who may be unqualified)<br>OR they require an intensive programme ≥25 hours of total therapy time per week, (eg 4-5 hours per day 5 days per week) some of which may be sessions with a therapy assistant, or group-based sessions in addition to their individual daily therapy programme |
| **TI 4** | **Very High level – very intensive** (eg 2 trained therapists to treat, or total 1:1 therapy >30 hrs/week)<br>Patient has very complex therapy needs requiring two trained therapists at a time (with or without a 3rd assistant)<br>– eg for complex physical handling needs, management of unwanted behaviours etc<br>OR they require a very intensive programme involving > 30 hours of total therapy time per week. |
| **Total** | **Total T score (TD + TI) :.............** |

**EQUIPMENT NEEDS**

Describes the requirements for personal equipment

| Code | Description | Basic Special Equipment | Highly Specialist Equipment |
|---|---|---|---|
| **E 0** | **No needs** for special equipment | | |
| **E 1** | Requires **basic special equipment** (off the shelf) | Wheelchair/seating<br>Pressure cushion<br>Special mattress<br>Standing frame<br>off-shelf orthotic<br>Other........................ | Environmental control<br>Communication aid<br>Customised seating<br>Customised standing aid<br>Customised orthotic<br>Assisted Ventilation<br>Other........................ |
| **E 2** | Requires **highly specialist equipment**<br>(eg Electronic assistive technology or highly customized equipment that is made or adapted specifically for that individual) | | |

Appendix 3: Shelford Safer Nursing Care Tool, 2013

| Shelford Group Safer Nursing Care Tool | | |
|---|---|---|
| Levels of Care | Patient Description | Example |
| **Level 0** | Needs met by provision of normal ward cares | Patient awaiting discharge |
| **Level 1a** | Acutely ill, requiring intervention or unstable with a greater potential to deteriorate | Post-operative care following complex surgery |
| **Level 1b** | In stable condition but dependant on nursing care to meet most/all of activities of daily living | Complex wound management |
| **Level 2** | May be managed within clearly designated beds, with required expertise; may require transfer to dedicated Level 2 facility/units | Continuous cardiac monitoring |
| **Level 3** | Needing advanced respiratory support and/or therapeutic support of multiple organs | Monitoring for compromised or collapse of two or more organs |
| Source: The Shelford Group Safer Nursing Care Tool, Shelford Chief Nurse Group Produced in conjunction with the Association of UK University Hospitals May 2013 | | |

Appendix 4: Northwick Park Dependency Score; July 2016

**NORTHWICK PARK DEPENDENCY SCORE – H (NPDS-H)**

**PATIENT DETAILS: Surname:** .................. **Forename(s):** .................
**Hosp No:** ..................... **Sex: Male/Female** **Date of birth:**.................
**NHS No**..........................**Diagnosis:**..................................................
**Date of assessment..../..../..... Completed by: CRM, Other Medic, Band 8, Band 7, Band 6, Other Band........**

FOR EACH ITEM, CIRCLE THE HIGHEST SCORE THAT APPLIES and answer any additional questions

**SECTION 1. BASIC CARE NEEDS**

**1. MOBILITY**
(Give most usual method of mobility around bay (hospital) or indoors (home))

| Description | Dependency |
|---|---|
| a) Walks fully independently | 0 |
| b) Independent in Electric / self-propelled chair | 1 |
| c) Walks with assistance / supervision of one | 2 |
| d) Uses attendant-operated wheelchair | 3 |
| e) Bed-bound (unable to sit in wheelchair) | 4 |
| f) Walks with assistance / supervision of two | 4 |

**2. BED TRANSFERS**

| Description | Dependency |
|---|---|
| a) Fully independent | 0 |
| b) Requires help from one person | 1 |
| c) Requires help from two people | 2 |
| d) Requires hoisting by 1, and takes <½ hr* **or** | 3 |
| e) Requires hoisting by 2, and takes <¼hr | 3 |
| f) Bed bound | 0 |

**2.1. FREQUENCY OF BED TRANSFERS**
If he/she needs help/supervision to transfer on/off bed

How many times do they get back to bed *for a rest* during the day?

☐ 0 ☐ 1 ☐ 2 ☐ More than 2

***Note:** It is very rare to hoist with one person, but occasionally happens when family members are in the home setting

**3. TOILETING BLADDER**
**3.1. MODE OF EMPTYING**
Which of the following does the patient use to empty their bladder?

| By DAY | | By NIGHT |
|---|---|---|
| ☐ | Toilet | ☐ |
| ☐ | Commode | ☐ |
| ☐ | Bottles | ☐ |
| ☐ | Catheter / convene | ☐ |
| ☐ | Bed-pan | ☐ |
| ☐ | Pads | ☐ |

**3.2. NEED FOR ASSISTANCE**
(Includes getting there, transferring onto toilet, cleaning themselves/changing and disposing of soiled pads, adjusting clothing, and washing hands afterwards.
IF USING BOTTLE: includes reaching for it, positioning and replacing it unspilt)

| Description | Dependency |
|---|---|
| a) Able to empty their bladder independently | 0 |
| b) Set-up only (eg copes if bottles left within reach) **or** | 1 |
| c) Has indwelling catheter/ convene | 1 |
| d) Needs help/supervision from 1, and takes less than ¼hr | 2 |
| e) Needs help from 1, and takes more than ¼hr | 3 |
| f) Needs help from 2, and takes less than ¼hr | 4 |

**3.3. FREQUENCY OF ASSISTANCE FOR EMPTYING BLADDER**
If he/she needs help to pass urine

How many times do they pass urine during the day (7am-11pm)?
☐ up to 4 times ☐ 5-6 times ☐ >6 times ☐ Help at night only

How many times do they pass urine during the night (11pm-7am)?
☐ 0 ☐ 1 ☐ 2 ☐ >2

**3.4. URINARY ACCIDENTS**
A urinary accident is the need to change soiled clothing or bed/chair linen. If pads are used as the mode of bladder emptying but urine does not leak outside of these then accidents do not occur

| Description | Dependency |
|---|---|
| a) No accidents or leakage from catheter / convene | 0 |
| b) Occasional accidents (Less than daily) | 1 |
| c) 1-2 accidents / leakage in 24 hrs | 2 |
| d) >2 accidents / leakage in 24 hrs | 3 |

**If scored 1: How many times per week?** 1 2 3 4 5 6
**If scored 3: How many times in 24 hrs?** 3 4 5 6

1



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**4. TOILETING BOWELS**

**4.1. NEED FOR ASSISTANCE**

(Includes getting to and transferring onto toilet, cleaning themselves/changing and disposing of soiled pads, adjusting clothing, and washing hands afterwards. IF HAS COLOSTOMY, includes emptying / changing bag hygienically)

| Description | Dependency |
|---|---|
| a) Able to empty their bowels independently | 0 |
| b) Set-up only (eg giving suppositories / enema) | 1 |
| c) Needs help/supervision from 1, and takes less than ¼hr | 2 |
| d) Needs help from 1, and takes more than ¼hr | 3 |
| e) Needs help from 2, and takes less than ¼hr | 4 |
| f) Needs help from 2, and takes more than ¼hr | 5 |

**4.2. FREQUENCY OF OPENING BOWELS** (or emptying Colostomy bag) **OR TRIAL OF EVACUATION**

☐ 2-3 times per week ☐ 4-5 times per week ☐ Once a day
☐ Twice a day ☐ > twice a day

**(Do not include faecal incontinence here)**

**What time/s of day do they normally open their bowels/ have trial of evacuation?**

| Morning | Midmorning | Midday | Afternoon | Evening | Bedtime |
|---|---|---|---|---|---|
| ☐07-10.30 | ☐10.30-12 | ☐ 12-2pm | ☐ 2-6pm | ☐ 6-9pm | ☐9pm-11pm |

☐ No specific time (Variable)

**How many times do they open their bowels at night (11pm-7am)?**

☐ 0 ☐ 1 ☐ 2 ☐ >2

**4.3. FAECAL ACCIDENTS**

A faecal accident is the need to change soiled clothing or bed/chair linen due to faecal soiling. If pads are used as the mode of faecal toileting but faeces do not leak outside of the pad then accidents do not occur. If bowels are opened once following suppositories/enema onto a pad this is "requires regular bowel regime"

| Description | Dependency |
|---|---|
| a) No faecal accidents | 0 |
| b) Requires regular bowel regimen - suppositories / enemas in order to remain continent | 1 |
| ***Enter Section 4: Care Needs assessment Item No. 4a*** | |
| c) Occasional faecal accidents (less than daily) | 2 |
| d) Regular faecal accidents | 3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **If scored 2: How many times per week?** | 1 | 2 | 3 | 4 | 5 | 6 |
| **If scored 3: How many times in 24 hrs?** | 1 | 2 | 3 | 4 | 5 | 6 |

Patient Name…………………… NHS No:…………………

**5. WASHING AND GROOMING**

(Includes washing hands and face, cleaning teeth, brushing hair, and shaving or applying make-up)

**NB. This item does not include bathing / showering**

| Description | Dependency |
|---|---|
| a) Able to wash and groom independently | 0 |
| b) Needs help to set up only (eg laying out things, filling bowl with water) | 1 |
| c) Needs help from 1, and takes less than ¼ hr | 2 |
| d) Needs help from 1, and takes more than ¼ hr | 3 |
| e) Needs help from 2, and takes less than ¼ hr | 4 |
| f) Needs help from 2, and takes more than ¼ hr | 5 |

**Note:** It is very rare to need help from 2 to groom unless patient requires support to sit up or restraint or suctioning when teeth are cleaned.

**6. BATHING / SHOWERING**

(Includes getting to bath/shower-room, transferring in and out, washing and drying) NB. If unable to bath or shower: Complete as for THOROUGH STRIPWASH/BED BATH

| Description | Dependency |
|---|---|
| a) Able to have bath/shower independently | 0 |
| b) Needs help to set up only (eg running bath soaping flannel etc) | 1 |
| c) Needs help from 1, and takes less than ½ hr | 2 |
| d) Needs help from 1, and takes more than ½ hr | 3 |
| e) Needs help from 2, and takes less than ½ hr | 4 |
| f) Needs help from 2, and takes more than ½ hr | 5 |

**7. DRESSING**

(Includes putting on shoes, socks, tying laces, putting on splint or orthosis)

| Description | Dependency |
|---|---|
| a) Able to dress independently | 0 |
| b) Needs help to set up only (eg laying out clothes) **or** | 1 |
| c) Needs incidental help from 1 (eg just with shoes) | 1 |
| d) Needs help from 1, and takes less than ¼hr | 2 |
| e) Needs help from 1, and takes more than ¼hr | 3 |
| f) Needs help from 2, and takes less than ¼ hr | 4 |
| g) Needs help from 2, and takes more than ¼ hr | 5 |

2

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**8.1. EATING**

| Description | Dependency |
|---|---|
| a) Entirely gastrostomy / nasogastric fed | 0 |
| b) Able to eat independently | 0 |
| c) Needs help to set up only (eg opening packs or passing special cutlery) **or** | 1 |
| d) Needs intermittent check/supervision from 1 | 1 |
| e) Needs help from 1, and takes less than ½ hr | 2 |
| f) Needs help from 1, and takes more than ½ hr | 3 |

**8.2. DRINKING**

| Description | Dependency |
|---|---|
| a) Entirely gastrostomy / nasogastric fed | 0 |
| b) Able to pour own drink and drink it independently | 0 |
| c) Able to drink independently if left within reach **or** | 1 |
| d) Able to drink independently but needs prompting to do so | 1 |
| e) Needs help or supervision, and takes less than ¼ hr | 2 |
| f) Needs help/supervision, and takes more than ¼ hr | 3 |

How many times in 24 hrs? ☐ 3 ☐ 4-6 ☐ 7or more

**8.3. ENTERAL FEEDING** (GASTROSTOMY or NASOGASTRIC TUBE)

| Description | Dependency |
|---|---|
| a) No enteral feeding/ manage feeds independently | 0 |
| b) Needs help to set up feed just once a day (indicate set up time) | 1 |
| c) Needs help to set up feed twice a day (indicate set up times) | 2 |
| d) Needs help to set up feed three times a day (indicate set up time) | 3 |
| e) Needs help to set up feed and extra flushes during the day | 4 |
| f) Needs help to set up feed and extra flushes both day and night | 4 |

Time feeds set up ☐Morning ☐Midday ☐Evening ☐Bedtime ☐Night

**9. SKIN PRESSURE RELIEF**

| Description | Dependency |
|---|---|
| a) Able to relieve pressure independently | 0 |
| b) Needs prompting only to relieve pressure | 1 |
| c) Needs help from 1 to relieve pressure/turn (4 hrly) | 2 |
| d) Needs help from 2 to relieve pressure/turn (4 hrly) (if continued throughout the night indicate >2 night interventions in Special Nursing Needs) | 3 |
| e) Skin marked or broken, needs 1 to relieve pressure/ turn (2 hrly) | 4 |
| f) Skin marked or broken, needs 2 to relieve pressure/turn (2 hrly) | 5 |

**10. SAFETY AWARENESS**

| Description | Dependency |
|---|---|
| a) Fully orientated, aware of personal safety | 0 |
| b) Requires some help with safety and orientation but Safe to be left for more than 2 hrs + could summon help in emergency | 1 |
| c) Requires help to maintain safety Could not be left for 2 hrs +could not summon help in an emergency | 2 |
| d) Requires at least hourly checks **or** constant supervision | 3 |

**11. COMMUNICATION**

| Description | Dependency |
|---|---|
| a) Able to communicate needs without help | 0 |
| b) Able to communicate basic needs with a little help or by using a communication aid or chart (<¼hr) | 1 |
| c) Able to communicate basic needs with help or by using a communication aid or chart (>¼hr ) | 2 |
| d) Able to respond to direct questions about basic needs | 3 |
| e) Responds only to gestures and contextual cues | 4 |
| f) No effective means of communication | 5 |

**If scored 1 or 2:**

**How many times does communication (outside of care activities) occur within 24 hours?**

☐ Less than twice ☐ 2-4 times ☐ More than 4 times

**12. BEHAVIOUR**

| Description | Dependency |
|---|---|
| a) Compliant and socially appropriate | 0 |
| b) Needs verbal /physical prompting for daily activities | 1 |
| c) Needs persuasion to comply with rehab or care | 2 |
| d) Needs structured behavioural modification programme | 3 |
| e) Disruptive, inclined to aggression | 4 |
| f) Inclined to wander off ward | 5 |

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## SECTION 2: SPECIAL NURSING NEEDS

| ADD 5 FOR EACH OF THE BELOW (if applicable) | Dependency |
|---|---|
| 1. Tracheostomy | 5 |
| 2. Open pressure sore / wound requiring dressings | 5 |
| 3. More than 2 interventions required at night | 5 |
| 4. Pt or relatives need substantial psychological support | 5 |
| 5. Infective isolation | 5 |
| 6. Intercurrent medical / surgical problem | 5 |
| 7. Needs one-to-one "specialing" | 5 |

| | NPDS TOTAL SCORES |
|---|---|
| SECTION 1: BASIC CARE NEEDS | .......... |
| SECTION 2: SPECIAL NURSING NEEDS | .......... |
| NPDS NURSING DEPENDENCY SCORE | .......... |

## SECTION 3: IN-PATIENT NURSING NEEDS

| Tick if applicable | Yes | No |
|---|---|---|
| 1.Maintenance of rehabilitation programme | ☐ | ☐ |
| 2.Complex feeding needs (requires skilled carer) | ☐ | ☐ |
| 3. Complex basic care needs (requires skilled carer) | ☐ | ☐ |
| 4. Complex discharge needs | ☐ | ☐ |
| 5. 3 or more people needed for basic care needs | ☐ | ☐ |
| 6. Active teaching of self-catheterisation | ☐ | ☐ |
| 7. Infective Isolation | ☐ | ☐ |
| 8. More than 2 night interventions | ☐ | ☐ |

| 1. TRACHEOSTOMY MANAGEMENT<br>Description | Dependency |
|---|---|
| a) No tracheostomy in situ / or self management | 0 |
| b) Maintenance tracheostomy intervention e.g changing inner tube, minimal suction <2 day | 1 |
| c) Active tracheostomy intervention e.g weaning, frequent suction 2-6 times a day | 3 |
| d) Maximal tracheostomy intervention e.g very frequent suction >6 per day or requires 2 people or very close monitoring | 5 |

| 2. WOUND DRESSING OR PROBLEMATIC STOMA DRESSINGS<br>Description | Dependency |
|---|---|
| a) No wound dressing / self management | 0 |
| b) Simple dressing (does not require Qualified staff) | 1 |
| c) Simple dressing – requires qualified staff intervention | 3 |
| d) Complex – requires qualified staff intervention or 2 people | 5 |

| 3. MEDICATION (Including remembering to take it, opening bottles etc) | |
|---|---|
| a) No medication OR able to take all medication independently | 0 |
| b) Supervised practise – patient dispenses & takes medication under supervision | 1 |
| c) Nurse dispenses and administers all medication | 2 |
| d) Requires additional time from qualified staff<br>tick e.g ☐ CD meds ☐ IV meds ☐ PEG meds ☐ Supervised practice | 3 |
| How many times per day does any medication need to be given?<br>1 2 3 4 5 More than 5 | |

| 4. PATIENT AND/OR FAMILY REQUIRE PSYCHOLOGICAL SUPPORT FROM NURSING/CARE STAFF | |
|---|---|
| a) No additional psychological support needed | 0 |
| b) Require frequent reassurance – can be provided by any care staff | 1 |
| c) Require psychological support from experienced nurse <2hours per week | 3 |
| d) Requires additional time from an experienced nurse >2 hrs/ week | 5 |

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| 5. SERIAL/ RESTING SPLINTS<br>Description | Dependency |
|---|---|
| a) No splints/able to apply own splints | 0 |
| b) Simple splint application (e.g Velcro splint) can be applied by **one person**, limb does not need prior stretching | 1 |
| c) Moderate splint application (e.g back slab and bandage) requiring application by **2 people** (or 2 required due to behavioural issues) | 2 |
| d) Complex splint application (e.g bivalve and bandage) stretching of limb required prior to application and requires **2 to apply** | 3 |

| 5.1. FREQUENCY OF SPLINT APPLICATION | | | |
|---|---|---|---|
| How frequently do they have their splint/s applied? | | | |
| Daytime | ☐Once | ☐Twice | ☐ Three or more |
| Night time | ☐Night splints | | |

| 6. POSTURAL MANAGEMENT (IN BED OR CHAIR)<br>Description | Dependency |
|---|---|
| a) Able to maintain own posture | 0 |
| b) Needs prompting or help from one to maintain posture/position, 1-3 times in 24 hours | 1 |
| c) Needs prompting or help from 1 to maintain posture/position, 4 or more times in 24 hours | 2 |
| d) Needs help from 2 to maintain posture/position, 1-3 times in 24 hours | 3 |
| e) Needs help from 2 to maintain posture/position 4 or more times in 24 hours | 4 |

| 7. INTERCURRENT MEDICAL/SURGICAL PROBLEM | Dependency |
|---|---|
| a) No intercurrent medical/surgical problem | 0 |
| b) Requires daily monitoring of vital signs | 1 |
| c) Requires 4 hourly monitoring of vital signs or specific intervention by a qualified nurse for less than 2 hours a day | 3 |
| d) Requires specific intervention by a qualified nurse for more than 2 hours a day | 5 |

| 8. ONE TO ONE SPECIALING | Dependency |
|---|---|
| a) No one to one specialing required | 0 |
| b) Needs specialing (no specific skill needed) | 1 |
| c) Requires specialing by a nurse/skilled carer with rehabilitation experience | 3 |
| d) Requires specialing either by a specialty trained nurse (mentally unwell) or by a qualified nurse (acutely unwell) | 5 |
| TIME SPECIALING REQUIRED<br>☐ Daytime only ☐ Night time only ☐ 24 hours a day | |

| TOTAL NPDS-H SCORE | |
|---|---|
| SECTION 1: BASIC NURSING NEEDS (65) | …………………… |
| SECTION 3: IN PATIENT NURSING NEEDS (35) | …………………… |
| TOTAL NPDS-H SCORE (Add section 1 + 3 only) | …………………… |

## SECTION 4: CARE NEEDS ASSESSMENT

| 1. STAIRS (Based on if they were at home.) | |
|---|---|
| Would they be able to go up/down stairs at home? | |
| a) Yes, without help (independent) | ☐ |
| b) Yes, with assistance/supervision | ☐ |
| c) No, unable to do stairs (stays on one level) | ☐ |
| d) No, does not have stairs at home | ☐ |

| 2. MAKING A SNACK / MEAL (at home) | |
|---|---|
| a) Not applicable as entirely gastrostomy fed | 0 |
| b) Able to make a snack and drink at home independently | 0 |
| c) Able to help themselves if a snack is left out in the kitchen | 1 |
| d) Needs meals or drinks putting in front of them | 2 |

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|---|---|---|

| 3. MEDICATION (Including remembering to take it, opening bottles etc) | |
|---|---|
| a) Not applicable (eg on no medication) | 0 |
| b) Able to take all medication independently | 0 |
| c) Able to help themselves if tablets left out in the morning | 1 |
| d) Requires help for medication to be given | 2 |
| If requires help, which times does medication need to be given? | |
| (Tick all that apply) ☐7am ☐10am ☐Midday ☐2pm ☐4pm ☐6pm ☐8pm ☐10pm ☐Other | |

| 4. Do they require skilled help from a NURSE or TRAINED CARER for any of the following tasks? | | |
|---|---|---|
| a) Suppositories / Enema | ☐ Yes | ☐ No |
| b) Stoma Care (Tracheostomy, gastrostomy etc) | ☐ Yes | ☐ No |
| c) Pressure Sore / wound dressing | ☐ Yes | ☐ No |
| d) Special medication (eg insulin injections) | ☐ Yes | ☐ No |

If skilled help is required

How many times a week? Who provides that help?

| Times per week | Family | Home Care | Nurse |
|---|---|---|---|
| for Supps ………… | ☐ | ☐ | ☐ |
| Stoma care ………… | ☐ | ☐ | ☐ |
| Wound care ………… | ☐ | ☐ | ☐ |
| Special Medication….. | ☐ | ☐ | ☐ |

| 5. Do they require help for DOMESTIC DUTIES? (Based on if they were at home) | | |
|---|---|---|
| a) Light housework | ☐ Yes | ☐ No |
| b) Heavy housework | ☐ Yes | ☐ No |
| c) Shopping | ☐ Yes | ☐ No |
| d) Laundry | ☐ Yes | ☐ No |

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## Appendix 5 **NHS Commissioning Board 2013**

| TERTIARY SPECIALISED REHABILITATION SERVICES- provided at regional / national level | | |
|---|---|---|
| Level 1: | **Specialised rehabilitation services**<br>Provided by specialised rehab teams led by consultants trained and accredited in the specialty of rehabilitation medicine (RM) (and/or neuropsychiatry): | |
| | Serving a regional or supra-regional population and taking patients with Category A needs – ie severe physical, cognitive communicative disabilities or challenging behaviours, with highly complex rehabilitation needs* that are beyond the scope of their local specialist rehabilitation services, and have higher level facilities and skilled staff to support these.<br>Collect and report full National Specialist Rehabilitation Dataset | Catchment: 1-3 million<br>Predominantly highly complex caseload:<br>At least 85% pts have Category A needs on admission<br>At least 70% pts with RCS-E score ≥11 cross-sectionally |
| LOCAL REHABILITATION SERVICES - provided at district level | | |
| Level 2: | **Local (district) specialist rehabilitation services**<br>Provided by inter-disciplinary teams led/supported by a consultant in RM, and meeting the BSRM standards for specialist rehabilitation services | |
| Level 2a | Led by consultant in RM. Serving an extended local population in areas which have poor access to level 1 services.<br>Take patients with a range of complexity, including Category B and some Category A with highly complex rehabilitation needs*<br>Collect and report full National Specialist Rehabilitation Dataset | Catchment: 600K-1 million<br>Mixed caseload<br>50-80% Category A needs on admission<br>50-70% RCS-E score ≥11 cross-sectionally |
| Level 2b | Led/supported by a consultant in RM. Serving a local population, predominantly patients with Category B needs.<br>Collect and report at least the minimum national dataset | Catchment: 250-500K<br>Less complex caseload eg<br>30-50 % Category A needs on admission<br>30-50% RCS-E score ≥11 cross-sectionally |
| Level 3: | **Local non-specialist services.**<br>Includes generic rehabilitation for a wide range of conditions, provided in the context acute, intermediate care and community facilities, or other specialist services (eg stroke units) | |
| Level 3a | Other specialist services led or supported by consultants in specialties other than RM - eg services catering for patient in specific diagnostic groups (eg stroke) with Category C needs.<br>Therapy / nursing teams have specialist expertise in the target condition | |
| Level 3b | Generic rehabilitation for a wide range of conditions, often led by non-medical staff, provided in the context acute, intermediate care and community facilities, for patients with Category D needs | |



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