Single referrals for inpatient and community rehabilitation

**AUTHOR** Lesley Standring, RN, is lead nurse for care of the elderly and rehabilitation at West Suffolk Hospital NHS Trust, Bury St Edmunds, Suffolk.


The introduction of a single system for inpatient and community rehabilitation stemmed from a desire to simplify access to rehabilitation services. It was intended that in turn this would ensure that more patients were assessed for their suitability. A specialist multidisciplinary team skilled in assessment would decide which model of rehabilitation would meet individual needs.

West Suffolk Hospital NHS Trust is a district general hospital providing care to approximately 470 patients. The acute hospital has two inpatient rehabilitation wards, one of which is a dedicated 12-bed stroke rehabilitation unit. In the west of Suffolk two community hospitals provide inpatient rehabilitation for patients locally and an intermediate care team provides time-limited rehabilitation within the patients’ own homes and nursing homes.

Historically patients were referred using separate forms and different entry criteria for each rehabilitation area. They were also identified for empty beds in an ad hoc way.

The four-hour A&E target affected patient flow, so it was vital that the discharge process was effective. Due to high bed occupancy levels patients were sometimes moved with little or no consideration for their rehabilitation needs. Some may not have had the opportunity to be screened for rehabilitation at all. Often papers were lost and those referring patients did not know when the rehabilitation placement might take place.

**Aims**

The single referral system aims to ensure all patients are assessed for suitability for rehabilitation and are in the right place to receive the level of rehabilitation they require and to improve communication with family/carers about the patient’s future needs.

In achieving this, the project would also:

- Improve ward staff knowledge of the resources and models of rehabilitation in different areas;
- Facilitate earlier identification of patients who would benefit from rehabilitation;
- Ensure the specialist multidisciplinary team was aware of patients with complex needs;
- Reduce the number of inpatient transfers, therefore reducing length of stay.

**Development**

Initially one referral form for all areas was developed, with the idea that referrals would be made on a single form and be vetted by a small multidisciplinary team who would allocate the patient to a waiting list for the appropriate area. After some discussion it was decided to link this to the specialist multidisciplinary team for older people, as described in the *National Service Framework for Older People* standard 4 (Department of Health, 2001). This requires all general hospitals caring for older people to have identified a specialist multidisciplinary team for older people, which works throughout the hospital to ensure older people receive the care they need.

Clinical guidelines were then developed with the older person’s team, which consisted of nurses, doctors, occupational therapists and physiotherapists. The guidelines provided information on who to refer, when to refer and how to refer.

Before the system went live it was suggested that the referral form should be electronic. After negotiations with the IT department a trial form was developed on the hospital intranet. This allowed all ward staff access to make referrals and linked directly to an electronic waiting list for all rehabilitation areas.

The electronic form was quicker and easier to complete than the paper version as it was linked directly to the hospital information support service.

<table>
<thead>
<tr>
<th>TABLE 1. NUMBER OF REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>January 2005</td>
</tr>
<tr>
<td>May 2005</td>
</tr>
</tbody>
</table>
so when a patient’s hospital number was entered the rest of their demographic information appeared automatically. This included:

- Full name;
- Date of birth;
- Age;
- NHS number;
- GP.

The remainder of the form consisted of drop-down boxes containing questions about the patient’s preadmission and referral status. These included drop-down menus on:

- Referral destination;
- Ward;
- Consultant;
- Social worker;
- Admission date;
- Methicillin-resistant Staphylococcus aureus status;
- Clostridium difficile status;
- Mental test scores;
- Barthel score (for activities of daily living);
- Estimated discharge date.

Additional sections were provided to record:

- Discharge plan;
- Diagnosis/current medical issues;
- Additional comments.

The section on assessment details included drop-down selections for:

- Breathing – requirement for oxygen, oxygen saturation and respiratory rate;
- Communication – dysphasia, hearing and sight;
- Cognition;
- Skin, including Waterlow score;
- Pain;
- Personal hygiene;
- Mobility/safety;
- Diet and fluids;
- Elimination – continence status.

Community teams were involved in discussions about the content of the form and the discharge process to ensure a whole-system approach was developed, as described in *Discharge From Hospital: Pathway, Process and Practice* (DoH, 2003).

Members of the community team did not have access to the hospital intranet and were unable to view referrals online, so it was decided that referrals would be faxed or e-mailed to them and they would review patients within 72 hours.

It was then necessary for other disciplinary groups to agree to and opt into the referral system. It was important that it was used by all staff making decisions about patient movement or placement, such as senior managers on call and site coordinators. Community teams were made aware that patients would have been assessed by a multidisciplinary specialist team before referrals were sent out, so it was likely that they would be suitable. This reduced the need for the community teams to review each patient.

**Training**

Before the new referral process was rolled out, all ward staff who might have to refer patients needed training in its use. Key staff members were trained to use the electronic system and educated about the different rehabilitation areas, what services they provided and entry criteria.

These key staff were allotted ward areas in which they trained as many staff as possible. They then provided ad hoc training sessions if problems were identified. Follow-on training after the system was rolled out was then provided as part of the trust’s discharge planning sessions.

**Process**

Patients are identified by the ward multidisciplinary team as being potentially suitable for rehabilitation. An electronic referral is generated and all patients referred are seen the next day by the team, who determine the following:

- Whether the patient is suitable;
- Which area would provide the most benefit for the patient;
- Whether the patient is medically stable to be transferred.

The information is then recorded on the online waiting list. The list can be viewed by the rehabilitation wards and the ward that created the referral so that they are both aware of the decision made by the team. When the rehabilitation wards have a patient planned for discharge, they identify a suitable patient to be admitted into the empty bed.

**REFERENCES**


---

**TABLE 2. REFERRALS BY WARD**

<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>75</td>
<td>15</td>
</tr>
<tr>
<td>May</td>
<td>102</td>
<td>19</td>
</tr>
</tbody>
</table>

**TABLE 3. REFERRAL DESTINATIONS**

<table>
<thead>
<tr>
<th></th>
<th>Acute rehabilitation</th>
<th>Community hospital rehabilitation</th>
<th>Intermediate care</th>
<th>Nursing home</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>46</td>
<td>27</td>
<td>1</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>May</td>
<td>62</td>
<td>41</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

*This article has been double-blind peer-reviewed.*

For related articles on this subject and links to relevant websites see [www.nursingtimes.net](http://www.nursingtimes.net)
Analysis of progress

The system was ready to roll out in January 2005. It was evaluated four weeks into the scheme, looking at information collected throughout January, and again during May.

Thirty-one more patients had been referred in May and patients had waited less time to be transferred to the appropriate area (Table 1, p34). This indicates that patients’ length of stay had been reduced, possibly because appropriate rehabilitation patients had been moved.

All referrals continued to be seen within 24 hours of the electronic form being generated.

Initially it was identified that the quality of the referrals was generally poor. Subsequently certain fields on the form have been made mandatory, which ensures the required level of detail is obtained before the patient is visited.

We were able to see the wards not identifying and referring patients and target them for training (Tables 2 and 3, p35). The data also identified the different diagnoses of referred patients and their ages (Tables 4 and 5, p36).

Benefits

The scheme has produced some definite benefits for patients and has improved the flow of patients through the trust.

All inpatient rehabilitation areas now have patients waiting to be transferred, which prevents unnecessary transfers and patients being placed in the wrong area.

The increased number of referrals and reduced time waiting for a rehabilitation bed indicates shorter stays.

Rehabilitation ward staff now have control over which patients they admit. Community hospitals have been able to take those who live locally, decreasing lengths of stay and enabling them to admit more patients from the acute hospital.

Patients who are referred are now involved and informed about their progress into rehabilitation by the specialist team. The specialist team has also been able to advise other professionals caring for patients with complex needs.

Recommendations

Over the next few months the data from the analysis will help us to plan for the future needs of the rehabilitation service. For example, a need for 12 rapid rehabilitation beds has been identified, where patients can have a week’s targeted inpatient therapy then either be discharged home or to community rehabilitation services.

The community team attendance at the multidisciplinary team round will be reinstated, which will ensure better communication and understanding of what each team has to offer, for example, when setting up a pathway for patients presenting at A&E with falls.

Overall the new system has simplified the referral procedure and has ensured that the multidisciplinary team can select the most appropriate patients to be transferred into rehabilitation beds.

### TABLE 4. REFERRAL BY DIAGNOSIS

<table>
<thead>
<tr>
<th>Month</th>
<th>Stroke</th>
<th>Falls, fracture orthopaedic</th>
<th>Acute</th>
<th>Dementia/confusion</th>
<th>Neurological</th>
<th>Respiratory</th>
<th>Cardiac</th>
<th>Palliative</th>
<th>Other</th>
<th>Cellulitis</th>
<th>Medical acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>14</td>
<td>29</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>16</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>14</td>
<td>36</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td>18</td>
<td>11</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

### TABLE 5. REFERRAL BY AGE

<table>
<thead>
<tr>
<th>Month</th>
<th>≤64</th>
<th>65–75</th>
<th>76–85</th>
<th>≥86</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>9</td>
<td>11</td>
<td>38</td>
<td>32</td>
</tr>
<tr>
<td>May</td>
<td>7</td>
<td>20</td>
<td>52</td>
<td>42</td>
</tr>
</tbody>
</table>