BEDDED COMMUNITY SERVICES TOOLKIT (WALES): BUNDLE B - REHABILITATION

The most commonly cited reason for transfer to bedded community services. However, the audits demonstrated variation in the level of rehabilitation actually delivered. Issues identified included:

- a lack of clear goal setting on transfer;
- poor communication with patients and their families regarding what to expect;
- variation in therapies input;
- facilities that do not support self-care by replicating ordinary living environments.

SPECIFIC CONSIDERATIONS (in addition to the Core Bundle for all bedded community services)

Rehabilitation is identified as a core requirement across each of the five core functions of community bedded facilities. However, in addition to the overarching principles and expectations for bedded community services, the following issues need to be considered if offering rehabilitation:

- **Agree clear goals and anticipated discharge destination (assume Home First) prior to transfer.** As described in the overarching principles, the plan must be co-produced with the individual and (with their permission) their family/carers.

  The plan must clearly set out the rehabilitation 'offer' and what the individual should expect to happen. The plan should be recorded and owned by the individual e.g. via 'My Personal Transfer and Recovery Plan'.

- **Reinforce that rehabilitation is 'everybody's business'.** Rehabilitation should commence on transfer, with tailored activities and positive risk-taking and shared decision-making to support the individual to become 'home ready'. Highly skilled generic support workers (enablers) will be key to delivering this approach. Informal carers/families, should be supported to be part of the team, where they are able and wish to do so.
  Skills should be developed through formal training modules and competency-based, experiential learning.
  Such learning should encompass the formation of therapeutic relationships and the enabling ethos.

- **Optimise prudent utilisation of the therapies workforce.** There is a clear need to ensure timely access to Allied Health Professional (AHP) expertise in bedded community services. To facilitate this, regional partnership need to understand the scope of their therapies resource across the system, and ensure that it is used effectively and efficiently.[1]

- **Consider the need for specialist space and equipment for rehabilitation.** As discussed in the overarching principles and expectations for all bedded community services, the environment must be designed to support the maximising of independence, in the context of person's home and usual activities.

  Where the Local/Regional Needs Assessment indicates that specialist rehabilitation is required (for example stroke, neurological, younger adults) the provision of specialist space and equipment such as gym facilities should be considered.

[1] https://gov.wales/sites/default/files/publications/2020-02/allied-health-professions-framwework-for-wales.pdf

LOCAL BEDDED COMMUNITY SERVICES PLANNING & COMMISSIONING CHECKLIST: REHABILITATION

 **Core Function 2: Rehabilitation** **Specific requirements in addition to the overarching principles and requirements for bedded community services**		
Expectation	**Action required to fully deliver:**	**Priority level:** High/Medium/Low
Specialist space and equipment where required e.g. rehabilitation for stroke/neurological conditions/younger adults.		
All staff receive training in rehabilitation and reablement skills.		
Informal carers/families, are supported to be part of the team delivering rehabilitation and recovery programmes, where they are able and wish to do so.		

SUGGESTED PERFORMANCE IMPROVEMENT MEASURES FOR CONSIDERATION

<table>
<tr><th colspan="2"> 

BEDDED COMMUNITY SERVICES : REHABILITATION
(in addition to overarching measures)</th></tr>
<tr><th>HOW MUCH DID WE DO?</th><th>HOW WELL DID WE DO IT?</th></tr>
<tr><td>Number of community beds available for rehabilitation
Number of referrals for rehabilitation received
Number of individuals receiving rehabilitation care in bedded community services</td><td>% individuals who need it, accessing specialist rehabilitation services within 48 hours
% individuals readmitted to acute care from the bedded community service
% staff receiving training in rehabilitation and reablement
Staff retention/sickness/satisfaction

PREMS</td></tr>
<tr><th colspan="2">IS ANYONE BETTER OFF?</th></tr>
<tr><td>Number of individuals who return to usual place of residence
Number of individuals reporting that they feel ‘home ready’ at the end of their stay in the bedded community service</td><td>% individuals returning to usual place of residence
% individuals reporting that they feel ‘home ready’ at the end of their stay in the bedded community service

PROMS</td></tr>
</table>