NHS
Ipswich and East Suffolk
Clinical Commissioning Group

Community Reablement Beds 2015/16 Referral Criteria

Definitions for community reablement beds highlighted below:

Reablement

General aim to help people accommodate their illness or condition by regaining confidence and learning/relearning the skills necessary for daily living.

Step up care

This describes a pathway for people who are tipping into or have tipped into a care crisis and who have a care need that cannot be managed within their own home or they cannot be left safely at home. At this time they may benefit from being stepped up into a community reablement bed. Any patient stepped up will be deemed ***medically stable*** by the referring clinician.

Step across care

This describes a pathway for people who are transferred from A&E / Frailty Assessment Base (FAB) following diagnostic assessment and treatment who require time limited bed based reablement care before returning to their own home. Any patient stepped across will be deemed ***medically stable*** by the referring clinician.

Step down care

This describes a pathway for people who have required an admission and who are subsequently medically stable but would benefit from further reablement before returning home. This may include early supported discharge. Any patient stepped down will be deemed ***medically stable*** by the referring clinician.

Criteria as follows:

Patients can be 'stepped up' by GP / admission avoidance teams ie Crisis Action Team (CAT) into a community reablement bed (this may be as a result of a clinical discussion between GP and EAU Consultant if required on Bleep 620). Patients can also be 'stepped across' from A&E or the Frailty Assessment Base (FAB). Patients are unable to be 'stepped across' from EAU.

Criteria A	• Aged over 18 Registered with an IESCCG GP • Medically stable on transfer (all patients must be discussed / reviewed by the appropriate doctor / GP / referring clinician and this should preferably be face-to-face), and recorded in the patients notes as appropriate • Requiring enablement support • Able to be cared for safely and with dignity within the care home, or own home • Not presenting an infection control risk to other patients within the environment • Have a predicted discharge date from the Community Reablement beds within 5-10 days, at which time the patient is predicted to return to a functional level where they could return home with: o On-going Community Health Care Team rehabilitation input o Onward referral to outside agency e.g. Red Cross o Basic assistive equipment o A new ACS package of care or the increase of an existing care package ***Likely input required alongside general enabling approach:*** • Short term reablement or non-complex reablement interventions • Review of discharge needs / possible further assessment for assistive equipment • Assessment by Social Worker / setting up of care package • Onward referral to community services • Possible consultant or GP review depending on needs • Appropriate nursing interventions ***Exclusion criteria*** New onset or increase in acute confusion where the medical / therapy team feel it would prevent discharge within 5-10 days.

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SYSTEM ESCALATION

Criteria during times of system escalation however focus may be on Ipswich Hospital (step across and step down care)

Criteria B	***In addition to Criteria A, the following criteria can be considered during escalation e.g. IHT being at Level 4 (Black). These patients are likely to exceed a 5-10 day length of stay however they should not normally exceed a 14 day length of stay. They may:*** • Require intensive multi-disciplinary input to promote self-care • Require a review of medication and education / supervision of compliance • Be listed for a community hospital bed for non-specialist rehab and where a bed is not available ***These patients may require:*** • Reablement and more complex rehabilitation interventions • Possible complex discharge planning • Onward referral to community services ***Exclusion criteria*** New onset or increase in acute confusion where the medical / therapy team feel it would prevent discharge within 10-14 days.
Criteria C	***Patients may be considered for transfer into reablement beds for the following, only where this has been agreed with the Escalation Managers or in consultation with the Director on-Call for IESCCG:*** Checklist and (where necessary) Assessment for NHS Continuing Healthcare complete. Also Section 5 complete and patient medically ready for discharge but NHS responsibility owing to: • Refusal of ACS care bed • Self-funding and confirmed start date for residential care
Criteria D	***Patients may be considered for transfer into community reablement beds for the following, only where this has been agreed with the Escalation Managers or in consultation with the Director on-Call for IESCCG:*** Checklist and (where necessary) Assessment for NHS Continuing Healthcare complete. Also Section 5 complete and patient medically ready for discharge but ACS responsibility owing to: • Patient is awaiting ACS services and a start date has not been confirmed • Patient is awaiting housing adaptations that have a completion date
If patients do not fit into any of the above criteria and providers still wish to access a Community Reablement bed; this will need to be discussed in the first instance with the Reablement Co-ordinators and then authorised by the Escalation Managers during office hours and by the Director on Call out of normal office hours. ***This might include non-weight bearing patients who are unable to be cared for at home (approval should be sought from the IESCCG Escalation Managers).***	