

## **The Rehabilitation Complexity Scale version 2: A clinimetric evaluation in patients with severe complex neurodisability**

Lynne Turner-Stokes DM FRCP $\Psi$ \*

Heather Williams MSc\*

Richard J Siegert PhD $\Psi$

$\Psi$ King's College London, School of Medicine,  
Department of Palliative Care, Policy and Rehabilitation  
\*Regional Rehabilitation Unit, Northwick Park Hospital

### **Address for Correspondence:**

Professor Lynne Turner-Stokes DM FRCP  
Regional Rehabilitation Unit,  
Northwick Park Hospital  
Watford Road  
Harrow, Middlesex. UK  
**HA1 3UJ**

E-mail: [Lynne.turner-stokes@dial.pipex.com](mailto:Lynne.turner-stokes@dial.pipex.com)

Tel: +44-(0)-208-869-2800

Fax: +44-(0)-208-869-2803

## **Abstract**

**Objective:** To evaluate clinimetric properties of the Rehabilitation Complexity Scale (RCS) in a neurorehabilitation inpatient sample.

**Design:** Observational cohort analysis in a tertiary specialist setting.

**Subjects:** 179 consecutive patients (mean age 44.5(sd15) years, Males:Females 110:69) with complex neurological disabilities, mainly following acquired brain injury.

**Methods:** Repeat RCS ratings of the level of care, nursing, therapy and medical interventions were examined for dimensionality, repeatability, consistency, and responsiveness; and compared with the Northwick Park Nursing and Therapy Dependency Scales (NPDS and NPTDA), the Functional Independence Measure (FIM) and Barthel Index, recorded at the start and end of treatment.

**Results:** Test-retest reliability confirmed the RCS to be repeatable (Kappa 0.93-0.96) and moderately responsive to changes in levels of intervention over the course of the programme, suggesting the need for serial evaluation. Coefficient-alpha was 0.76 and item-total correlations all  $>0.50$ , with moderate-high loadings on the first principal component. Factor analysis showed two clear factors ('Nursing/medical care', and 'Therapies'). The RCS demonstrated good convergent and discriminant validity with the NPDS and NPTDA, but some ceiling effect. FIM motor and Barthel scores correlated well with basic care and nursing scores (Spearman rho -0.65 to -0.79), but less well with therapy (rho -0.26) and medical (rho -0.28 to -0.33) scores.

**Conclusion:** In this cohort, the RCS provided a reliable, valid and moderately responsive profile of rehabilitation interventions, separating into two main subscales. It usefully identified medical and therapy inputs not captured by the FIM and Barthel Index, which are commonly used to define case complexity in rehabilitation.

**Key words:** Rehabilitation, casemix, measurement, clinimetrics

## **Introduction**

Assessing the complexity of rehabilitation needs presents a considerable challenge throughout the world. In the US, Canada, Australia, and many parts of Europe, classifications of rehabilitation complexity have relied on physical dependency (measured by the Functional Independence Measure (FIM™)\* (1) or Barthel Index (2)) as a surrogate for rehabilitation needs (3, 4). These classifications may work reasonably well where patients are medically stable and physical independence is the main target of intervention. However, they do not capture needs for medical or specialist nursing care, nor do they specifically address the need for cognitive, behavioural or other psychological interventions.

The Northwick Park nursing Dependency Scale (NPDS)(5, 6) and the equivalent Therapy Dependency Assessment tool (NPTDA) (7, 8) provide a detailed evaluation of requirements for basic care, nursing, therapy and medical needs, in terms of both the disciplines involved and the proportion of time spent on different rehabilitation activities (including cognitive/behavioural interventions and family support). A common underlying principle of these instruments is that they are designed to be applied either prospectively to measure ‘needs’ for care/intervention, or retrospectively to describe the level of intervention actually provided (ie what the patient ‘gets’)(9), so that in future they could be applied as a framework for quantifying gaps in service provision. However, they are somewhat time-consuming to administer, and may not be practical for routine application in services with a high throughput of cases.

The Rehabilitation Complexity Scale (RCS) has been similarly designed to provide a simple measure of the complexity of rehabilitation needs and/or interventions, which is timely to apply and takes account of basic care, specialist nursing, therapy and medical interventions. A preliminary exploration (10) of the RCS (version 1) demonstrated that it is simple and practical for routine use across a range of specialist rehabilitation services. In a multi-centre cross-sectional analysis (10), it showed clear differences between tertiary (or ‘complex specialised’) and secondary (or ‘district specialist’) rehabilitation services, on the basis of their relative proportions of complex cases (and the staffing levels to cope with them). Clinicians reported favourably on utility, content and face value, but noted some ceiling effects for patients with very complex needs. The therapy subscale, which recorded total hours of therapy intervention\*, was found to be difficult to rate prospectively. The instrument was revised to form the RCS version 2, in which the care, nursing and medical scales remain the same, but the therapy scale has been divided into two subscales reflecting a) the number of therapy disciplines and b) the overall intensity of treatment.

The term ‘clinimetrics’ was initially coined by Alvan Feinstein in the 1980s (11) in recognition of the fact that items within rating tools developed in clinical settings are often chosen for their clinical relevance, rather than their measurement or scaling properties. Scale development is therefore driven by clinical content, which is valued over uni-dimensionality – often the principal concern of psychometrics. Nevertheless

---

\* FIM™ is a trademark of the Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.

\* The RCS version 1 may be found in the original article Turner-Stokes et al 2007 (10)

it is important to understand the extent to which a given instrument can be used as a 'measure', as opposed to simply an 'assessment tool'(12).

The items in the RCS were chosen for their content value, on the basis that needs for care, nursing, therapy and medical input are the principal 'causes' of case complexity which (together with length of stay) will ultimately determine the cost of providing a rehabilitation programme for a given individual. Item levels are broadly ordinal, but were designed to reflect clinically important features that may influence care planning, rather than being chosen for their interval qualities. Item scores are expected to be in some way cumulative, but it is pertinent to know whether they may reasonably be 'summed' to a total score as an overall indicator of caseload complexity; and if not, whether they can be grouped, or should be reported individually.

The aim of the present paper is to report on the key clinimetric properties of the RCS version 2 - that is its reproducibility, validity, feasibility, responsiveness and interpretability (13) - and to investigate its performance in a sample of patients with highly complex rehabilitation needs. We also explored its dimensionality and relationship with the other rehabilitation dependency scales (the NPDS and the NPTDA), as well as with the Barthel Index and the FIM, in order to evaluate its potential as a measure of caseload complexity in complex neurological rehabilitation settings.

## **Methods**

### *Setting*

The Regional Rehabilitation Unit at Northwick Park provides a tertiary post-acute rehabilitation service for younger adults with severe complex neurological disabilities - including physical, cognitive, behavioural and/or communicative problems (14). The unit serves a wide catchment area in the South-East of England (population > 5 million) to support people with complex rehabilitation needs that are beyond the scope of their local rehabilitation services. Set in an acute general hospital, it offers 24-hour medical care and caters in particular for people who have on-going medical problems, and cannot possibly be managed on an out-patient or domiciliary basis. This setting was chosen because it has a high proportion of patients with complex needs.

### *Sample*

Data were collated for a total of 179 consecutive patients (110 males and 69 females) during a 30 month period between 1.6.06 and 1.12.08. Of these, 173 had data collected at discharge from the programme (the remaining 6 were short admissions only). Demographic details are given in Table 1.

**Table 1. Demographic characteristics of the study population (n=179)**

Mean age	44.5 years (SD=15, Range 15-80)	
Male/female ratio	110:69	
Mean length of stay	78 days (SD=64, Range 12-469)	
DIAGNOSIS	Number	%
Acquired brain injury:	139	78%
Cerebrovascular accident	88 (67%)	
Traumatic	26 (21%)	
Anoxic	14 (7%)	
Other eg Inflammatory	11 (5%)	
Spinal cord injury	20	11%
Peripheral nerve condition (eg Guillain Barre syndrome, critical illness neuropathy)	15	8%
Other	5	3%

## Measures

### *Rehabilitation Complexity Scale (RCS)*

The RCS is a 16-point measure with five items (10) (see Appendix 1): Basic care and support (C: range 0-3); Nursing (N: 0-3); Therapy (T) – the number of therapy disciplines (TD: 0-3) and overall therapy intensity (TI: 0-3); Medical (M: 0-3).

### *Northwick Park Dependency Scale (NPDS)*

The NPDS is a measure of nursing needs/interventions specifically developed for rehabilitation settings (5). It is shown to be a valid measure of nursing dependency (15, 16) and is used increasingly widely both in the UK and abroad (17, 18). It has a total score ranging from 0-100, and is subdivided into two domains, Basic Care Needs (BCN) (12 items, score range 0–65) and Special Nursing Needs (SNN) (7 items, score range 0-35). Scoring levels reflect the number of carers and time taken to complete the task. It is translated by a computerised algorithm into a direct measure of care hours (11).

### *Northwick Park Therapy Dependency Assessment (NPTDA)*

The NPTDA is an equivalent scale to assess therapy needs/interventions in a neurological rehabilitation setting (7, 8). It provides an ordinal score of therapy dependency (range 0-100) consisting of 26 items in two principal domains (direct and indirect intervention). Scoring levels reflect the number of therapists and approximate

intervention times. Once again, a computerised algorithm translates this into an estimate of the total therapy hours, subdivided by discipline and by domain (7).

### *Application of measures*

In this evaluation, all three measures were applied retrospectively in respect of the *levels of intervention provided*. This application was chosen for its greater objectivity and precision, and also for comparability with the FIM and Barthel Index (see below). They were recorded as part of the unit's routine practice - RCS, NPDS and NPTDA ratings are rated at fortnightly intervals, based on the average of the preceding two week's interventions for each patient. NPDS scores were rated by their 'named nurse', and NPTDA scores by the treating therapy team. RCS scores were recorded during the multidisciplinary ward round, by the treating team: C and N scales reported by the nurses, and M scale by the doctors. T scale scores were computed from routinely recorded therapy intervention times. RCS, NPTDA and NPDS ratings for start and end of treatment were chosen to represent the period corresponding as closely as possible to the FIM and Barthel Index ratings (see below).

### *Repeatability*

Test-retest repeatability was tested during a 7-month period from June 2006 to January 2007.

**RCS Care, nursing and medical sub-scale:** C, N, and M scores were rated for all current in-patients (usually n=18-20) by the treating clinical team at the beginning of each weekly ward-round meeting. At the end of the meeting (approximately 1.5-2 hours later) RCS scores were again rated by the same clinical team, without reference to the first rating. The ward round thus acted as a distracter task. Over the 7-month period, 316 paired ratings were obtained.

**RCS Therapy sub-scale:** T scores were extracted from computerised therapy records on this unit. During the same 6-month period, T scores for RCS version 1 (based on total therapy hours of intervention per week) were computed in parallel with T scores for RCS version 2 (TD (number of disciplines involved plus TI overall therapy intensity) (n=307 paired ratings).

### *The Barthel Index (BI) and Functional Independence Measure (FIM)*

The BI is a 10-item measure recorded on a range of 0-20(19). The FIM is an 18-item scale (1), subdivided into a motor scale (13-items, range 7-91) and a cognitive scale (5 items, range 5-35). FIM and BI scores were extracted (20) from the UK Functional Assessment Measure (UK FIM+FAM) (21) which is routinely applied at the start (within 10 days of admission date) and at end (within the last 7 days) of the programme. In accordance with the manual(22), scores reflected the individual's observed level of dependence, not what they *could* or *might* do.

### **Data Collection and Clinimetric Analyses**

De-identified data were extracted from the unit's computerised records. Analysis was undertaken using SPSS v15 or STATA v8, using classical approaches within the framework recommended by Medical Outcomes Trust(23).

- *Conceptual and measurement model:* The conceptual model for development of the RCS is described briefly above.
- *Dimensionality:* The Kaiser-Meyer-Olkin measure of sampling adequacy and Bartlett's test of sphericity were used to confirm suitability for factor analysis(24). Dimensionality was examined using exploratory (EFA) and confirmatory factor analysis (CFA). EFA involved a principal component analysis with orthogonal (Varimax) rotation. Horn's method of Parallel Analysis was used as the objective criterion for how many factors to rotate(25, 26). CFA was conducted on RCS data collected for the same patients, but at discharge (n=173), using the AMOS-16 structural equation software programme within SPSS.
- *Reliability:*
  - Reproducibility (Test-retest repeatability) was evaluated for individual items and total scores by testing agreement using quadratic-weighted Cohen's kappa statistics (STATA).
  - Internal consistency of the RCS was examined using Cronbach's alpha and item-total correlations in the reliability analysis module of SPSS.
- *Validity:* Construct-related validity was evaluated using one set of ratings per patient at the start of treatment. In the absence of a clear gold standard against which to test criterion validity, concurrent convergent and discriminant validity were assessed through Spearman correlations with the NPDS and NPTDA scores.
- *Relationship with other measures:* Correlations with the FIM and BI were also examined to compare their potential to evaluate case complexity in this context.
- *Responsiveness* was evaluated by testing for significant differences between paired scores recorded at the start and end of the programme (Wilcoxon signed rank test).

## **Results**

### *Feasibility*

In this study, the RCS took less than 1-2 minutes to administer by a team who was familiar with the scoring manual and used the score regularly in routine practice.

### *Descriptive statistics*

Table 2 shows the descriptive statistics for the RCS, NPDS, NPTDA, FIM and BI scores at the start and end of the programme. As expected for this complex group, RCS scores clustered at the top end of the scale, with a median of 11 (IQR 9-12). There was some evidence of a ceiling effect in the RCS scores, when compared with the more detailed Northwick Park dependency scales - particularly for the T score (see Fig 1).

**Table 2. Descriptive statistics for scores at the start and end of treatment**

	Start of treatment (n=179)			End of treatment (n=173)			Wilcoxon signed rank test		Direction of change
	Mean (SD)	Median (IQR)	Range	Mean (SD)	Median (IQR)	Range	z	p	
<b>RCS scores</b>									
Care (0-3)	1.4 (0.8)	1 (1-2)	0-3	1.0 (0.9)	1 (0-1)	0-3	-7.4	<0.001	↓
Nursing (0-3)	2.3 (0.7)	2 (2-3)	0-3	1.8 (0.9)	2 (1-3)	0-3	-7.3	<0.001	↓
Therapy Disciplines (0-3)	2.6 (0.5)	3 (2-3)	2-3	2.8 (0.4)	3 (3-3)	1-3	-4.7	<0.001	↓
Therapy Intensity (0-3)	2.2 (0.6)	2 (2-3)	1-3	2.4 (0.5)	2 (2-3)	1-3	-2.8	<0.01	↑
Medical (0-3)	2.1 (0.7)	2 (2-3)	0-3	1.5 (0.9)	2 (1-2)	0-3	-7.1	<0.001	↓
Total (0-15)	10.7 (2.2)	11 (9-12)	4-15	9.4 (2.6)	10 (7-11)	3-15	-6.8	<0.001	↓
<b>NPDS scores</b>									
Basic care needs	20.7 (13.3)	18 (11-31)	0-52	13.3 (13.7)	9 (3-21)	0-50	-8.9	<0.001	↓
Special nursing needs	4.6 (6.0)	5 (0-5)	0-25	3.3 (4.9)	0 (0-5)	0-25	-3.3	<0.001	↓
Total NPDS	25.3 (17.7)	22 (11-39)	0-72	16.6 (17.4)	11 (3-25)	0-65	-8.7	<0.001	↓
Estimated care hours per week	43.1 (18.4)	42 (32-60)	0-77	30.6 (20.4)	28 (14-42)	0-74	-8.7	<0.001	↓
<b>NPTDA scores</b>									



Total NPTDA	24.7 (7.7)	25 (19-30)	8-44	27.6 (7.5)	28 (23-33)	6-50	-4.4	<0.001	↑	
Estimated total therapy hours per week	21.4 (8.9)	20 (16-26)	6-60	24.3 (8.8)	23 (19-29)	5-63	-4.2	<0.001	↑	
<b>FIM and Barthel Index</b>										
Barthel Index (range 0-20)	8.7 (5.7)	9 (4-12)	0-20	14.2 (6.2)	16 (11-20)	0-20	-	10.4	<0.001	↑
FIM Motor	44.5 (22.9)	43 (27-61)	13-91	66.1 (24.7)	75 (54-85)	13-91	-	10.6	<0.001	↑
FIM Cognitive	23.1 (9.3)	24 (17-31)	5-35	25.9 (8.7)	28 (22-33)	5-35	-8.3	<0.001	↑	

RCS: Rehabilitation Complexity Scale, NPDS: Northwick Park nursing Dependency Scale, NPTDA: Northwick Park Therapy Dependency Assessment

FIM: Functional Independence Measure (Motor and Cognitive subscales), SD = Standard Deviation, IQR = Inter-quartile range

### *Dimensionality*

Table 3 shows the results of a principal components factor analysis on the correlations of the RCS items. All five items loaded ‘moderate’ to ‘high’ on the first un-rotated principal component with loadings ranging from 0.52-0.79. Only the first two components had Eigen values >1, together accounting for 68% of the total variance in scores. Parallel analysis indicated a two factor solution, which was rotated using a Varimax procedure.

- The first factor appears to be ‘Nursing/medical’ care which accounted for 44% of the variance. The C, N and M items all loaded high (0.65-0.88) on this factor and low (<0.15) on factor 2.
- The second factor appears to be ‘Therapy’, accounting for 24% of the variance. The two therapy items (TD and TI) both loaded above 0.80 on this factor and low on factor 1.

**Table 3: Results of principal components factor analysis with orthogonal rotation on the correlations of the five RCS items using start of treatment scores (n=179)**

RCS item	Un-rotated principal component loading		Varimax rotation Orthogonal factor loading	
	Factor 1 Eigen value 2.2	Factor 2 Eigen value 1.2	Factor 1	Factor 2
Care (C)	0.75	-0.37	<b>0.83</b>	0.09
Nursing (N)	0.79	-0.40	<b>0.88</b>	0.08
Therapy Disciplines (TD)	0.52	0.71	0.06	<b>0.88</b>
Therapy Intensity (TI)	0.60	0.62	0.17	<b>0.84</b>
Medical (M)	0.62	-0.23	<b>0.65</b>	0.14

### RCS – Rehabilitation Complexity Scale

Confirmatory factor analysis, conducted on RCS scores at discharge (n=173), examined both a one- and a two-factor model. The one-factor model, with all five RCS items loading on a single underlying factor, showed a relatively poor fit with a Goodness of Fit Index (GFI) = 0.95, Comparative Fit Index (CFI) = 0.92, an Adjusted Goodness of Fit Index (AGFI) = 0.84, and Chi-square = 25.36 (df=5, p=0.000). The two-factor model (factor 1: C, N and M items; factor 2 TD and TI) had an excellent fit with a GFI = 1.0, CFI = 1.0, an AGFI = .98, and Chi-square = 1.92, (df=4, p=0.750).

### *Reproducibility*

Test-retest repeatability: Weighted Kappa values for agreement between repeated RCS ratings (n=316 data pairs) were 0.93, 0.96 and 0.94 for the care, nursing and medical subscales respectively, which constitutes ‘almost perfect’ agreement according to the interpretation of Landis and Koch (27). Agreement between T scores for versions 1 and 2 (TD+TI) (n=307 paired ratings) showed ‘substantial’ overall agreement (weighted kappa 0.69). Although a small bias towards higher ratings for

version 2 reached statistical significance at a numerical level (Wilcoxon  $z = -8.3$ ,  $P < 0.001$ ), this did not affect the median scores (which were 5 for both versions) nor agreement for the total RCS scores (weighted kappa 0.92).

Internal consistency: The coefficient alpha for the 5-item RCS scale was 0.76. Item-total correlations were all moderate or high - C: 0.75, N: 0.78, TD: 0.51; TI 0.58 and M: 0.65.

*Validity and relationship with other measures*

In terms of convergent and discriminant validity, we expected to find a close relationship between the RCS care and nursing (C and N) items and the NPDS; and between the two therapy measures (RCS T score and NPTDA), but weaker correlations across the therapy/nursing divide.

Table 4 presents the correlations with the NPDS, NPTDA, BI and FIM scores. A threshold for significance of  $p < 0.01$  was adopted to allow for the multiple tests. The RCS total score demonstrated moderately strong correlations with the NPDS and NPTDA ( $\rho = 0.49-0.79$ ,  $p < 0.001$ ). However, within the subscales there were differential correlations. Only the T scale correlated with the NPTDA ( $\rho = 0.72$ ), whilst the NPDS correlated strongly with the C, and N items (0.70-0.80), and to a lesser extent with the M item (0.38) but only weakly with the T scale (0.26). These relationships suggest that the RCS-T score reflects the needs for therapy intervention and the RCS-C and -N scores reflect care and nursing needs - but that, as expected, these are relatively independent of each other.

Because BI and FIM are measures of independence (as opposed to dependency), negative correlations with the RCS, NPDS and NPTDA were expected, and indeed found. Table 4 demonstrates that, although the RCS showed an overall relationship with these scores ( $\rho = -0.47$  to  $-0.72$ ), the FIM and BI were most closely related to the Care and Nursing items. By contrast, the Therapy score showed only modest associations with the BI and FIM Motor scales ( $\rho = -0.26$ ), but a stronger correlation with the FIM cognitive scale ( $\rho = -0.44$ ) – a relationship reflected also in the NPTDA score. Meanwhile the M item showed little or no relationship with either the FIM or BI.

**Table 4. Spearman correlations between RCS items (n=179) and associations with the Northwick Park Dependency Scales, Barthel Index and FIM at start of treatment.**

	Care	Nursing	Therapy TD+TI	Medical	Total	NPDS	NPTDA
<b>Rehab Complexity Scores</b>							
Nursing	0.64**						
Therapy (TD+TI)	0.18	0.23					
Medical	0.32*	0.44**	0.20				
Total RCS	0.72**	0.79**	0.64**	0.64**			
<b>NP Dependency scores</b>							
Total NPDS	0.80**	0.70**	0.26	0.38**	0.73**		
Total NPTDA	0.16	0.18	0.72**	0.19	0.49**	0.22	
<b>Barthel and FIM scores</b>							
Barthel Index	-0.76**	-0.65**	-0.26	-0.28*	-0.67**	-0.85**	-0.26
FIM Motor	-0.79**	-0.69**	-0.26	-0.33*	-0.72**	-0.88**	-0.26
FIM Cognitive	-0.33*	-0.33*	-0.44**	-0.17	-0.47**	-0.47**	-0.52**

Spearman Rank Correlation tests: \*\*p<0.001, \*p<0.01, (to account for multiple tests the threshold for significance was taken as p<0.01 – values above this are considered non-significant).

RCS: Rehabilitation Complexity Scale: Subscales: C = Care, N=Nursing, T=Therapy, M=Medical

NPDS: Northwick Park nursing Dependency Scale,

NPTDA: Northwick Park Therapy Dependency Assessment

BI: Barthel Index, FIM: Functional Independence Measure (Motor and Cognitive subscales)

*Responsiveness*

We did not expect the RCS overall to change markedly during the programme, even though we anticipated that the relative components of care/nursing and therapy might change. Table 1 summarises the changes in RCS, NPDS and NPTDA scores between the start and end of treatment. Overall there was a small, but significant, reduction in RCS - principally reflecting the reduction in care, nursing and medical (C+N+M) needs (Wilcoxon z -9.0 p<0.001) - whilst the therapy component (TD+TI) increased overall (Wilcoxon z -4.6 p<0.001). Fig 2 shows an example single case analysis of serial RCS measurements at fortnightly intervals, during a 5-month rehabilitation programme. Care and nursing needs gradually fell during the stay, but therapy needs followed a variable course as the interventions changed at different stages of the programme. Similar patterns were reflected also in the NPTDA/NPDS scores and hours of intervention.

**Table 5: Clinimetric evaluation of the Rehabilitation Complexity Scale: Summary of findings according to the Medical Outcomes Trust framework.**

Attribute	Criteria	Evaluation
<b>Conceptual and measurement model</b>	<b><i>The rationale for and description of the concept and the populations that the measure is intended to assess</i></b>	
	Clinical content and design	The Rehabilitation Complexity Scale (RCS) is a 5-item ordinal scale, scored on a range of 0-15 Designed to provide a simple measure of the complexity of rehabilitation needs and/or interventions, which is timely to apply and takes account of basic care, specialist nursing, therapy and medical interventions. In this evaluation, it was tested in the context of 'interventions provided'.
	Dimensionality	Exploratory and confirmatory factor analyses showed strong evidence that the RCS has two distinct dimensions ('Nursing/medical care' and 'Therapy')
<b>Reliability</b>	<b><i>The degree to which the instrument is free from random error</i></b>	
	Internal consistency	Cronbach's alpha 0.76 and item-total correlations (0.51-0.78) showed moderate internal consistency
	Reproducibility	Test-retest repeatability after 2 hours using the ward-round as a distracter task: Quadratic-weighted Kappa values were 0.93, 0.96 and 0.94 for the care, nursing and medical items respectively - constituting excellent agreement. Repeatability for Therapy (TD and TI) items was <u>not</u> tested in this evaluation.
<b>Validity</b>	<b><i>The degree to which the instrument measures what it purports to measure</i></b>	
	Content	The RCS care (C), nursing (N), therapy (T) and medical (M) items are the principal 'causes' of case complexity, which (together with length of stay) ultimately determine the cost of a rehabilitation episode.
	Criterion-related	Not testable - no accepted gold stand currently exists
<b>Responsiveness</b>	<b><i>Ability to detect change over time where real changes occur</i></b>	
	Change: admission to discharge	RCS scores changed significantly over the course of a 3-4 month stay but the items changed in different directions: Care, nursing and medical interventions (C+N+M) reduced (Wilcoxon z -9.0 p<0.001); whilst therapy interventions(TD+TI) increased (Wilcoxon z -4.6 p<0.001).

<b>Interpretability</b>	<b><i>The degree to which easily understood meaning can be assigned to the quantitative scores</i></b>	
	Clinical meaning	The RCS is recommended to be reported by item: eg RCS 8 = C2 N1 T4 M1, as the level descriptors provide a clinical description of needs/interventions that is useful for treatment planning. This evaluation also supports summation into two subscales: Nursing medical care (C+N+M) and Therapy (TD+TI).
<b>Burden</b>	<b><i>The time, effort or other demands of administering the instrument</i></b>	
	Time to administer	The RCS is designed to be intuitive and requires minimal training. In this study, it took less than 1-2 minutes to administer by a team who was familiar with the scoring manual and used the score regularly in routine practice.
<b>Alternative modes of administration</b>		None currently available
<b>Cultural and language adaptations</b>		None currently available

\* RCS T score = Therapy Disciplines (TD) +Therapy Intensity (TI)

## ***Discussion***

This evaluation represents a clinimetric analysis of the RCS within the context of a specific group of patients with severe complex neurodisability. Although a full psychometric analysis was beyond the scope of this study, our findings are summarised under the Medical Outcomes Trust framework (23) in Table 5.

The RCS was feasible to score regularly in routine practice, taking 1-2 minutes to administer by a team familiar with scoring. C, N and M scores were shown to be highly repeatable; and version 2 (which differs from version 1 only with respect to the T scores) gave equivalent results at a clinical level. Repeatability of the T scores has not been tested in this evaluation.

RCS scores changed differentially over the course of a 3-4 month stay - care, nursing and medical interventions reducing, whilst therapy scores increased. Whilst at first sight this might seem surprising, it resonates with clinical experience that, as patients become less dependent on basic nursing and medical care for their survival and health, they become more active in therapies. The observed variability over time was reflected in other measures. This suggests that serial recording may be required to capture changes in rehabilitation needs and the interventions that are provided to meet them, throughout the course of the rehabilitation programme.

We found good evidence for convergent and discriminant validity of the RCS in relation to other measures of nursing and therapy dependency - although there was some potential for bias, as scores were necessarily applied by the same treating team. Ceiling effects (especially in the therapy subscale) underline the need to use more detailed scales to measure complexity at the top end of the scale. Comparison with the FIM (motor) and Barthel, suggests that these measures of physical disability provide a good indication of needs for care and nursing, but are relatively poor indicators of needs for therapy or medical intervention. The closer relationship between the FIM cognitive score and level of therapy intervention is also expected in this group of patients with complex disability. As patients get back on their feet and become relatively independent for basic care activities, residual cognitive problems may still preclude the transition to home - but their needs for cognitive therapies (eg psychology) may increase. This underlines the importance of including specific indicators of therapy and medical needs in the evaluation of rehabilitation complexity.

The RCS items were originally chosen for their clinical importance as the key determinants of cost of a rehabilitation episode. However, we wished to know whether they could be summed to a total score, as an overall indicator of caseload complexity. Item-total correlations and Cronbach's alpha showed moderate internal consistency, suggesting that the five subscales are broadly cumulative. Nevertheless, exploratory and confirmatory factor analyses both showed strong evidence for two distinct dimensions ('Nursing/medical care' and 'Therapy'). This, together with the differential pattern of change over time, suggests that the Therapy items provide additional information with respect to rehabilitation complexity, and should be recorded separately. Therefore, although our previous study(10) demonstrated that a total RCS score had some discriminatory value in distinguishing services on the basis of caseload complexity, the findings presented here suggest that summation into two subscales is more appropriate. On the other hand, the four components each have differential impact for staffing requirements, and between them provide a profile of rehabilitation needs. Separate reporting of item scores (eg C2 N1

T3 M1) may therefore be required to facilitate clinical interpretation, in a manner analogous to the Glasgow Coma Scale.



In addition to those already mentioned, the authors recognise a number of limitations to this study:

1. It was confined to a single centre with a particularly complex group of patients undergoing neurological rehabilitation. Whilst it was pertinent to evaluate use of the RCS in this group, because of the anticipated ceiling effects, the majority of patients in this cohort had severe physical disability. Further work is now required to evaluate the RCS as a measure of rehabilitation needs across a broader range of conditions and rehabilitation settings.
2. Our confirmatory factor analysis was undertaken on discharge scores from the same group of patients as the exploratory factor analysis. Even though the two sets of scores were demonstrated to be significantly different, the results must be interpreted with caution and further confirmatory analysis is required in different patient groups to confirm the factor structure of the RCS.
3. The relationship between rehabilitation *needs* and *intervention* is complex, and many clinicians feel frustrated by the lack of resources to meet all their patients' needs for rehabilitation. As noted above, the RCS, NPDS and NPTDA are designed to be applied either prospectively (to predict 'needs') or retrospectively (to describe the level of intervention provided) and so ultimately to quantify unmet need. In this study, we used retrospective application to reflect the actual rehabilitation *intervention* provided, in order to maximise objectivity and precision. Further evaluations are required, employing both prospective and retrospective designs, to establish the relationship between need and intervention, which was not addressed in this study.

In summary, the RCS is a new measure designed to evaluate complexity of rehabilitation needs/intervention. This study has provided evidence for its validity, reliability and responsiveness to change in patients with complex neurological disabilities. It provides a profile of rehabilitation needs, which could be used to distinguish case complexity in rehabilitation; and it includes areas of care that are missing from other routinely used instruments, such as the FIM and BI. Because of ceiling effects, however, caution should be exercised in its application to the most complex cases, where more detailed evaluation may be required using the NPDS and NPTDA.

It is anticipated that some further adjustment or adaptation may be needed to capture the various features that relate to complexity in different clinical settings – for example in neuro-psychiatric units, recording the level of 'risk' of harm to self or others may be more relevant than the need for acute medical care. Further work is now warranted to explore the use of the RCS in different rehabilitation settings and with other patient groups.

## **Figure legends**

### **Legend to Figure 1:**

In these sunflower plots, each petal represents one pair of data. Data both start and end of programme are included to ensure representation across the range of the scale.

Comparison of the RCS therapy score with the NPDTA and the NPDS shows significant ceiling effects for both the therapy and care/nursing scales, but particularly the former.

### **Legend to Figure 2:**

Care and nursing interventions show a gradual reduction over the course of the programme, whilst therapy intervention are more variable over time. Whilst the RCS scores are 'blunter' they follow a similar pattern to the more detailed scores and care hours

## **Acknowledgements**

The authors gratefully acknowledge the hard work of the RRU staff in collecting the data presented in this study, and the co-operation of the patients to whom it belongs. Special thanks are due to Jo Clark, Sarah Harris, Hilary Rose and Aung Thu, for their roles in co-ordinating data collection. Financial support for preparation of the manuscript was kindly provided by the Luff Foundation and the Dunhill Medical Trust.

**Copies of the Rehabilitation Complexity Scale**, and indeed the NPDS and NPDTA are available free of charge from the corresponding author.

**Ethics approval:** The Regional Rehabilitation Unit gathers this outcome data routinely in the course of clinical practice. Research Ethics Committee permission has been obtained to report the data retrospectively for research and audit purposes.

**Competing interests:** Outcome measurement is a specific research interest of our centre. The RCS, NPDS, the NPCNA were all developed through this department, but are disseminated free of charge. Professor Turner-Stokes is lead author on the papers which describe their initial development and validation, as well as that of the UK version of the FIM+FAM. However, none of the authors has any personal financial interests in the work undertaken or the findings reported.

**Copyright:** The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, an exclusive licence (or non exclusive for government employees) on a worldwide basis to the BMJ Publishing Group Ltd and its Licensees to permit this article (if accepted) to be published in the Journal of Neurology, Neurosurgery & Psychiatry editions and any other BMJPG products to exploit all subsidiary rights, as set out in the licence (<http://jnnp.bmjournals.com/fora/licence.pdf>).

## References

1. Heinemann AW, Linacre JM, Wright BD, Hamilton BB, Granger C. Relationships between impairment and physical disability as measured by the Functional Independence Measure. *Arch Phys Med Rehabil* 1993; 74(6): 566-573.
2. Mahoney FI, Barthel DW. Functional evaluation: the Barthel Index. *Md State Med J* 1965; 14: 61-5.
3. Sutherland JM, Walker J. Challenges of rehabilitation case mix measurement in Ontario hospitals. *Health Policy* 2008; 85(3): 336-48.
4. Eagar K. The Australian National Sub-Acute and Non-Acute Patient casemix classification. *Aust Health Rev* 1999; 22(3): 180-96.
5. Turner-Stokes L, Tonge P, Nyein K, Hunter M, Nielson S, Robinson I. The Northwick Park Dependency Score (NPDS): a measure of nursing dependency in rehabilitation. *Clin Rehabil* 1998; 12(4): 304-18.
6. Turner-Stokes L, Nyein K, Halliwell D. The Northwick Park Care Needs Assessment (NPCNA): a directly costable outcome measure in rehabilitation. *Clin Rehabil* 1999; 13(3): 253-67.
7. Turner-Stokes L. The Northwick Park Therapy Dependency Score (NPTDA): Development, preliminary evaluation and application. Department of Health R&D Project Grant Report ref 030/0066; 2006.
8. Turner-Stokes L, Shaw A, Law L, Rose H. Development and initial validation of the Northwick Park Therapy Dependency Assessment. *Clin Rehabil* 2009; In press.
9. Turner-Stokes L. Developing casemix classification systems for rehabilitation in the UK. In: *Patient Classification Systems International, 23rd Conference.*; 2007; Venice.
10. Turner-Stokes L, Disler R, Williams H. The Rehabilitation Complexity Scale: a simple, practical tool to identify 'complex specialised' services in neurological rehabilitation. *Clin Med* 2007; 7(6): 593-599.
11. Feinstein AR. Clinimetric perspectives. *J Chron Dis* 1987; 40(6): 635-640.
12. Hobart JC, Cano SJ, Zajicek JP, Thompson AJ. Rating scales as outcome measures for clinical trials in neurology: problems, solutions, and recommendations: with Web-based appendix. *Lancet Neurol* 2007; 6(12): 1094-1105.
13. Dekker J, Dallmeijer AJ, Lankhorst GJ. Clinimetrics in rehabilitation medicine: current issues in developing and applying measurement instruments. *J Rehabil Med* 2005; 37(4): 193-201.
14. Nyein K, Thu A, Turner-Stokes L. Complex specialized rehabilitation following severe brain injury: a UK perspective. *J Head Trauma Rehabil* 2007; 22(4): 239-47.
15. Post MW, Visser-Meily JM, Gispen LS. Measuring nursing needs of stroke patients in clinical rehabilitation: a comparison of validity and sensitivity to change between the Northwick Park Dependency Score and the Barthel Index. *Clin Rehabil* 2002; 16(2): 182-9.
16. Hatfield A, Hunt S, Wade DT. The Northwick Park Dependency Score and its relationship to nursing hours in neurological rehabilitation. *J Rehabil Med* 2003; 35(3): 116-20.

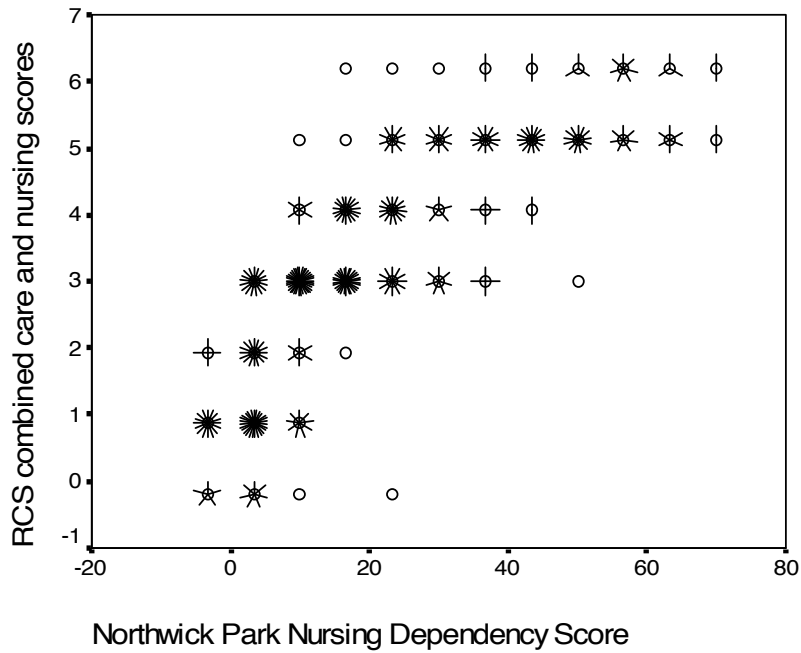
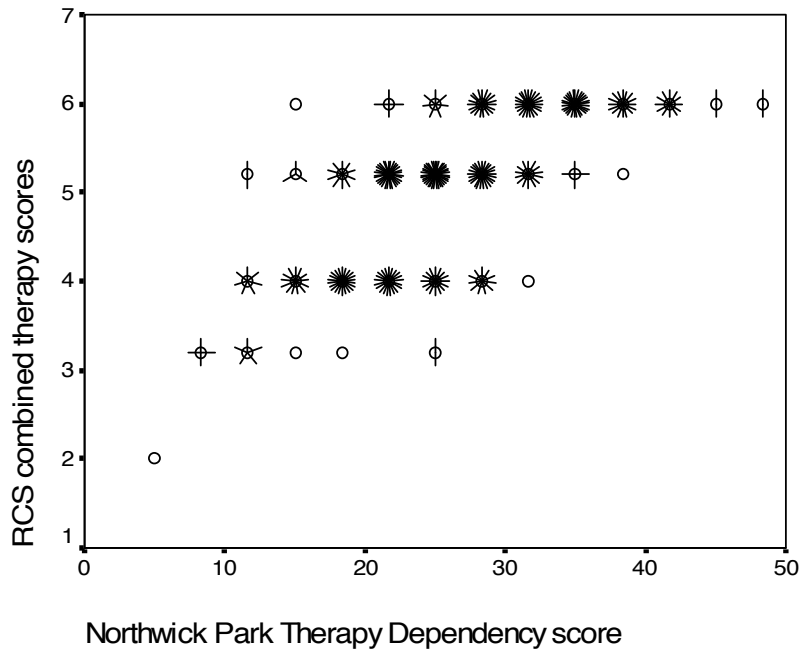
17. Skinner A, Turner-Stokes L. The use of standardised outcome measures for rehabilitation in the UK. *Clin Rehabil* 2005; 20(7): 609-15.
18. Svensson S, Sonn U, Sunnerhagen KS. Reliability and validity of the Northwick Park Dependency Score (NPDS) Swedish version 6.0. *Clin Rehabil* 2005; 19(4): 419-425.
19. Collin C, Wade DT, Davis S, Horne V. The Barthel ADL Index: a reliability study. *Int Disabil Stud* 1988;10:61-3.
20. Nyein K, McMichael L, Turner-Stokes L. Can a Barthel score be derived from the FIM? *Clin Rehabil* 1999; 13(1): 56-63.
21. Turner-Stokes L, Nyein K, Turner-Stokes T, Gatehouse C. The UK FIM+FAM: development and evaluation. *Clin Rehabil* 1999; 13(4): 277-87.
22. Turner-Stokes L. UK FIM+FAM (Functional Assessment Measure) Scoring manual version 1.1. London: Northwick Park Hospital. On behalf of the UK FIM+FAM Users Group; 1999.
23. Assessing Health Status and quality of life instruments: attributes and review criteria. *Qual Life Res* 2002; 11: 193-205.
24. Pett MA, Lackey NR, Sullivan JJ. Making sense of factor analysis: The use of factor analysis for instrument development in health care research. Thousand Oak, California.: Sage Publications; 2003.
25. Horn JL. A rationale and test for the number of factors in factor analysis. *Psychometrika* 1965; 32: 179-185.
26. Zwick WR, Velicer WF. Factors influencing five rules for determining the number of components to retain. *Psychol Bull* 1986; 99: 432-442.
27. Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics* 1977; 33: 159-17

## Appendix 1: The Rehabilitation Complexity Scale

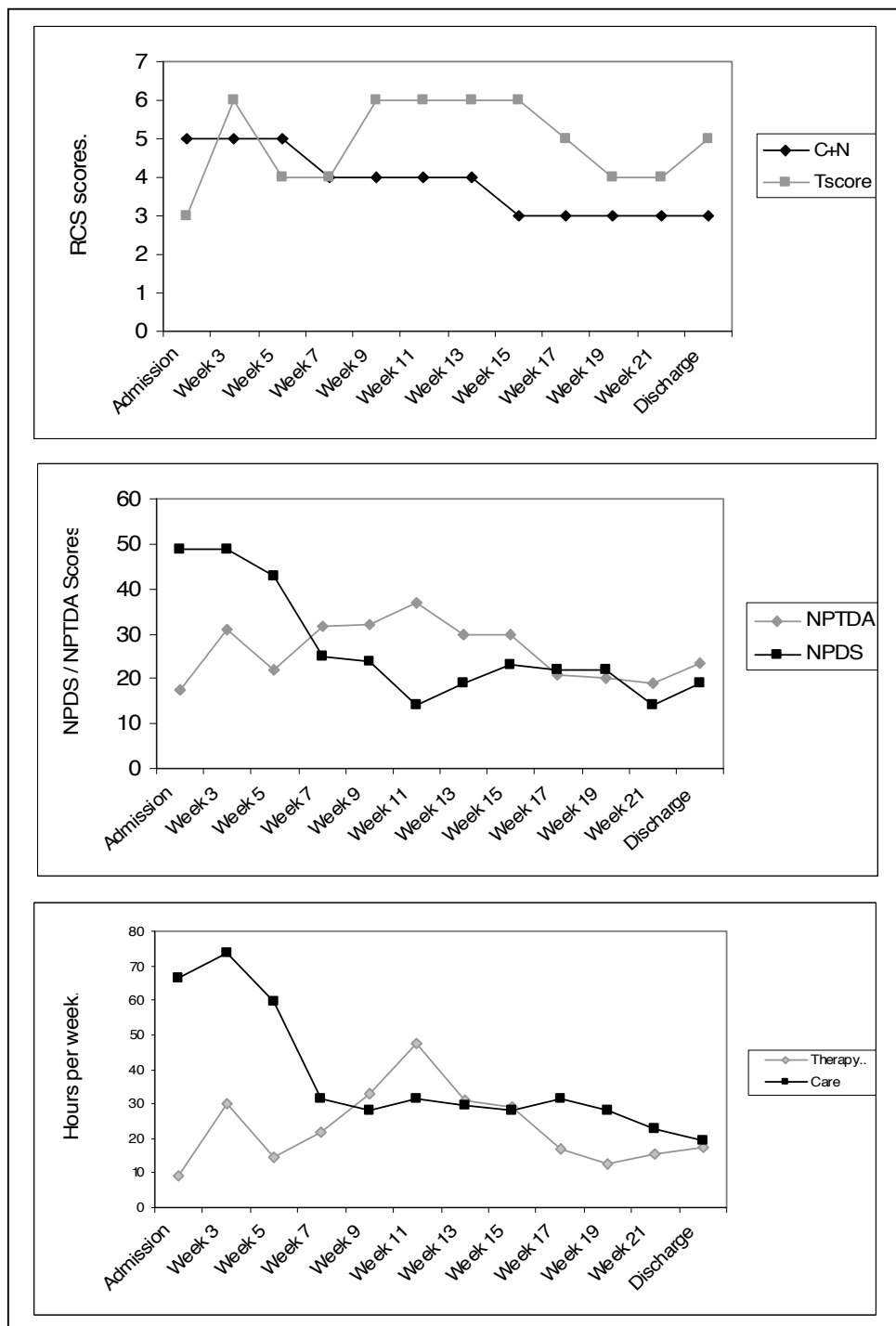
<b>PATIENT IDENTIFICATION</b>																		
<b>Name:</b>		<b>Hospital No:</b>	<b>Date of score:...../...../.....</b>															
<b>For each subscale, circle highest level applicable*</b>																		
<b>BASIC CARE AND SUPPORT NEEDS</b>																		
<i>Describes the approximate level of intervention required for basic self-care</i>																		
<b>C 0</b>	Largely <b>independent</b> in basic care activities																	
<b>C 1</b>	Requires <b>help from 1 person</b> for most basic care needs																	
<b>C 2</b>	Requires <b>help from 2 people</b> for most basic care needs																	
<b>C 3</b>	Requires <b>help from &gt;2 people</b> for basic care needs <b>OR</b> Requires constant <b>1:1 supervision</b>																	
<b>SKILLED NURSING NEEDS</b>																		
<i>Describes the level of intervention required from qualified or skilled rehab nursing staff</i>																		
<b>N 0</b>	No needs for skilled nursing																	
<b>N 1</b>	Requires intervention from a <b>qualified nurse</b> (e.g. for monitoring, medication, dressings etc)																	
<b>N 2</b>	Requires intervention from <b>trained rehabilitation nursing staff</b>																	
<b>N 3</b>	Requires <b>highly specialist nursing care</b> (e.g. for tracheostomy, behavioural management etc)																	
<b>THERAPY NEEDS</b>																		
<i>Describes the approximate level of input that is required from therapy disciplines</i>																		
<b>Disciplines:</b> State <b>number of different therapy disciplines</b> required to be <u>actively</u> involved in <u>treatment</u>																		
<b>TD 0</b>	<b>0</b>	<b>Tick therapy disciplines involved:</b> <table border="0"> <tr> <td>Physio</td> <td>Psychology</td> <td>Orthotics</td> </tr> <tr> <td>O/T</td> <td>Counselling</td> <td>Prosthetics</td> </tr> <tr> <td>SLT</td> <td>Music/art therapy</td> <td>Rehab Engineer</td> </tr> <tr> <td>Dietetics</td> <td>Play therapy</td> <td>Other:</td> </tr> <tr> <td>Social work</td> <td></td> <td></td> </tr> </table>		Physio	Psychology	Orthotics	O/T	Counselling	Prosthetics	SLT	Music/art therapy	Rehab Engineer	Dietetics	Play therapy	Other:	Social work		
Physio	Psychology			Orthotics														
O/T	Counselling			Prosthetics														
SLT	Music/art therapy			Rehab Engineer														
Dietetics	Play therapy	Other:																
Social work																		
<b>TD 1</b>	<b>1</b> disciplines only																	
<b>TD 2</b>	<b>2-3</b> disciplines																	
<b>TD 3</b>	<b>≥4</b> disciplines																	
<b>Intensity:</b> State <b>overall intensity of trained therapy intervention</b> required																		
<b>TI 0</b>	<b>No therapy intervention</b> (or<1 hour total/week - Rehab needs met by nursing/care staff or self-exercise programme)																	
<b>TI 1</b>	Low level – <b>less than daily</b> (eg assessment / review / maintenance / supervision) <b>OR Group therapy only</b>																	
<b>TI 2</b>	Moderate – <b>daily intervention 1:1</b> (+/- assistant) <b>OR very intensive Group programme</b> of ≥6 hours/day																	
<b>TI 3</b>	High level – <b>very intensive 1:1 intervention</b> (eg 2 trained therapists to treat, or total 1:1 therapy >25 hrs/week)																	
<b>Total</b>	<b>Total T score (TD + TI) :.....</b>																	
<b>MEDICAL NEEDS</b>																		
<i>Describes the approximate level of medical care environment required for medical/surgical management</i>																		
<b>M 0</b>	<b>No active medical intervention</b> (Could be managed by GP on basis of occasional visits)																	
<b>M 1</b>	<b>Basic investigation / monitoring / treatment</b> (Requiring non-acute hospital care, Could be delivered in a community hospital with day time medical cover)																	
<b>M 2</b>	<b>Specialist medical intervention – for diagnosis or management/procedures</b> (Requiring in-patient hospital care in DGH or specialist hospital setting)																	
<b>M 3</b>	<b>Acutely sick or potentially unstable medical condition</b> (Requiring 24 hour on-site acute medical cover)																	
<b>TOTAL</b>	<b>C:</b>	<b>N:</b>	<b>T:</b>															
	<b>M:</b>	<b>Summed score: /15</b>																

(\*NB More detailed instructions for application are available on request from the corresponding author)

**Figure 1: ‘Sunflower’ plots of the RCS Therapy scores with the NPTDA, and the summed RCS Care + Nursing scores with the NPDS.**



**Figure 2: Serial RCS scores in a single case episode of approximately 5 months stay compared with NPDS/ NPTDA scores, and care and therapy hours per week for the equivalent time points**





## The Rehabilitation Complexity Scale version 2: A clinimetric evaluation in patients with severe complex neurodisability

Lynne Turner-Stokes, Heather Williams and Richard J Siegert

*J Neurol Neurosurg Psychiatry* published online July 8, 2009

doi: 10.1136/jnp.2009.173716

---

Updated information and services can be found at:

<http://jnp.bmj.com/content/early/2009/07/08/jnp.2009.173716>

---

	<i>These include:</i>
<b>Data Supplement</b>	"Web Only Data" <a href="http://jnp.bmj.com/content/suppl/2010/01/28/jnp.2009.173716.DC1.html">http://jnp.bmj.com/content/suppl/2010/01/28/jnp.2009.173716.DC1.html</a>
<b>References</b>	Article cited in: <a href="http://jnp.bmj.com/content/early/2009/07/08/jnp.2009.173716#related-urls">http://jnp.bmj.com/content/early/2009/07/08/jnp.2009.173716#related-urls</a>
<b>P&lt;P</b>	Published online July 8, 2009 in advance of the print journal.
<b>Email alerting service</b>	Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

---

Advance online articles have been peer reviewed, accepted for publication, edited and typeset, but have not yet appeared in the paper journal. Advance online articles are citable and establish publication priority; they are indexed by PubMed from initial publication. Citations to Advance online articles must include the digital object identifier (DOIs) and date of initial publication.

---

To request permissions go to:

<http://group.bmj.com/group/rights-licensing/permissions>

To order reprints go to:

<http://journals.bmj.com/cgi/reprintform>

To subscribe to BMJ go to:

<http://group.bmj.com/subscribe/>



## Topic Collections

Articles on similar topics can be found in the following collections

[Disability](#) (155 articles)  
[Injury](#) (411 articles)  
[Neurological injury](#) (334 articles)  
[Trauma](#) (412 articles)  
[Trauma CNS / PNS](#) (334 articles)

---

## Notes

---

Advance online articles have been peer reviewed, accepted for publication, edited and typeset, but have not yet appeared in the paper journal. Advance online articles are citable and establish publication priority; they are indexed by PubMed from initial publication. Citations to Advance online articles must include the digital object identifier (DOIs) and date of initial publication.

---

To request permissions go to:

<http://group.bmj.com/group/rights-licensing/permissions>

To order reprints go to:

<http://journals.bmj.com/cgi/reprintform>

To subscribe to BMJ go to:

<http://group.bmj.com/subscribe/>