Rehabilitation Pathway for complex multi-trauma patients (levels 2a / 1) December 2015

To date, there has been no rehabilitation pathway written for complex multi-trauma patients (i.e. with an ISS score ≥ 15) in the Wessex Region. This pathway is for patients with the greatest rehabilitation need i.e. levels 1 and 2a using the BSRM definitions (2009, 2010). These patients are a priority in terms of clinical need and cost to the NHS. This document has been written in conjunction with local health / social workers, patients and commissioners, and in reference to the evidence base. The pathway aims at ideal care irrespective of whether it exists currently.

Pathway

Acute Care

Patients following a traumatic injury are taken to either:

A/ University Hospitals Southampton (UHS) as the Multi-trauma Centre (MTC), or

B/ A local Trauma Unit (TU). The patient may then be transferred to the MTC as a secondary transfer.

With this level of injury, the patient is invariably sited in an Intensive Care Unit (ITU) whether at the MTC or TU. A Rehabilitation Prescription, or equivalent document, should be filled in within 72 hours by a Rehabilitation Specialist (either Rehabilitation Consultant or Rehabilitation trained AHP – Band 7 or upwards) as per national trauma guidelines. If possible / appropriate, a holistic assessment should be undertaken including family members / carers as appropriate. This should include physical, cognitive, communication, psychological and social needs and relevant history.

If this is not appropriate at this point, it is expected that this would be done within the first 10 days and patients with, or expected to have, complex needs be identified. The Rehabilitation Complexity Score and the patient categorisation tool will assist in determining such patients.

The rehabilitation specialist should have access to the full multi-disciplinary team (MDT) for their expertise as needed including nursing, PT, OT, Consultant in Rehabilitation Medicine, Psychologist, Psychiatrist, Dietetics, etc. The MDT should meet regularly to discuss the changing needs of patients in the acute setting.

Acute rehabilitation should start as soon as clinically safe following medical protocols. Reassessment should occur regularly, at least weekly, as patient status changes quickly at this point in their journey.

When the patient is deemed medically stable enough so that their rehabilitation needs outweigh their dependence on acute care, the RP or equivalent should be re-assessed. At this point (at the latest), the most appropriate (in terms of being able to meet therapeutic need) and local rehabilitation facility should be identified and informed of the patient. The patient and / or carers

should be involved in any decision making about possible facilities. Ideally, centres should be informed earlier if the patients' likely journey can be foreseen with clinical experience.

Rehabilitation Specialists in the acute settings should know relevant rehabilitation facilities and be able to provide an extensive handover. Patients should be accepted within rehabilitation centres within two weeks of referral. (Patients may transfer to a local acute TU while awaiting referral / admission. Similar handover should occur to, and on from, the TU. Rehabilitation should continue while the patient is at the TU.)

Rehabilitation Centres

There are clear guidelines around the expectations of rehabilitation facilities including the service and team involved (See BSRM 2002, 2009, 2010). There are also clear outcome requirements from UKROC for such centres. This document does not aim to repeat this information. However, rehabilitation centres must be clearly patient focused and goal driven. They must have a strong, well trained and full MDT which meets regularly and can demonstrate evidence of regular training / CPD. Rehabilitation centres should be patient friendly in terms of environment, resources and culture. They must have access to social services / workers as part of the team. They must have all the resources / equipment requisite for providing appropriate treatment.

On arrival at a rehabilitation centre, appropriate, patient driven SMART goals should be set with the patient / carers and the MDT within the first week. These goals should be reviewed on a regular basis – two to four weekly. The patient / carers should receive regular feedback from these meetings as should the patient's GP. The RP, or equivalent, should be repeated at appropriate time frames as part of this process. This information should also be fed back to commissioners and social workers.

Nursing care plans should be initiated within 24 hours of arrival. Initial programme planning should be holistic addressing all needs identified on the RP or equivalent. Goals should be both long and short term. Length of stay in the centre should be agreed between the MDT and family at an early point – although this might be revised later. This will aid discharge planning both for clinicians, social services and families. All relevant agencies should be involved in planning for return to home / supported accommodation etc.

It is essential that there is flexibility in planning and treatment so that patient programmes can be tailored to individual patient needs rather than service needs. Rehabilitation centres should have access to appropriate vocational rehabilitation facilities / expertise and such interventions start at an early stage.

At an appropriate stage, as agreed by the MDT and the patient / carer, referral to a local community service should be commenced. It is expected that the specialist rehabilitation service will support local community services that may not have the expertise or experience regularly dealing with such patients. It is also expected that these services will have the option for re-admission to the Rehabilitation Centre if further goals / changes in condition mean that the patient would benefit from further input. Such patients will often benefit from long term intermittent follow up. Advances in telecommunication should be utilised to ease this process if appropriate.

The patient should have a named key worker at every stage of their journey who will act as their first point of contact and advocate through the system. The individual who is the key worker may change through the different stages of the process but the patient should always know who they can contact.

Community services should have skilled professionals with the relevant experience to support such patients at home both in terms of health care needs and social care / support. Ongoing support for vocational rehabilitation in the community should be considered. Appropriate voluntary agencies should be involved from as early as possible to enhance patient / carer support / care. All equipment should be delivered in a timely fashion so that patient transfers occur smoothly. Risk assessments should occur prior to patient discharge so that community teams can support patients safely.

Quality Measures

1. RP or equivalent filled in by Rehab Specialist (Cons or AHP B7), within 72 hrs y / n / NE
2. Holistic r/v – multiple professionals including psychosocial ax by 10/7 y / n / NE
3. Evidence of reassessment (at least weekly) in acute setting (if appropriate) y / n / NE
4. Evidence of daily rehabilitation (if appropriate) input by MDT PT, OT, SLT, Psychology etc. ?

---

1. Date of medical stability clearly recorded y / n / NE
2. Re-assessment of RP or equivalent within few days of above date? Y / n / NE
3. Evidence of communication to Rehab Centre within 2 days of above date? Y / n / NE
4. Evidence of involvement of family / carers in above decision making process concerning rehab centre? Y / n / NE
5. Evidence of goal setting in acute setting if not transferred y / n / NE

---

1. Patient accepted at rehab centre within 2/52 of medical stability date y / n / NE
2. Evidence of goal setting with patient / family / carer involvement, in first week y / n / NE
3. Evidence of long term and short term goals y / n / NE
4. Evidence of review of goals and RP within 4/52 and 8/52 y / n / NE
5. Evidence of voc rehab consideration (if appropriate) y / n / NE

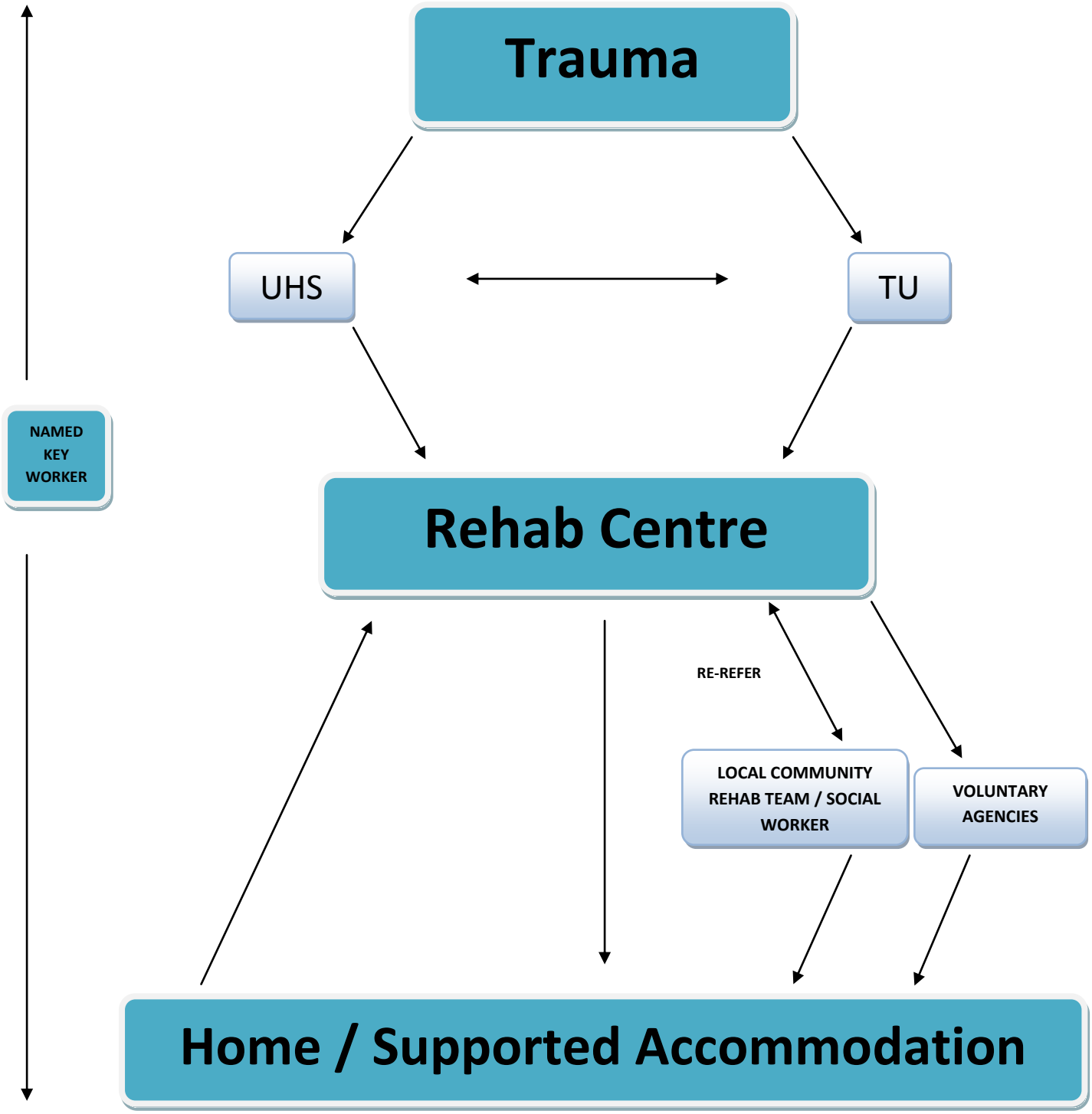
6. Evidence of clearly assigned key worker at 1/52, 4/52, 10/52 y / n / NE

7. Evidence of relevant clinical and QOL Outcome measures at rehab centre y / n / NE

8. Evidence of communication with: GP, Social Worker, Voluntary agencies. y / n / NE

NE = no evidence

Category 1 / 2a Patient Rehabilitation Pathway



Wessex Trauma Network