Royal Stoke University Hospital Major Trauma Rehabilitation Team

1. Structure

1.1 WTE Consultants in Rehabilitation Medicine

- 2 Consultants holding joint appointments at RSUH (UHNM NHS Trust) and Haywood Hospital (SSOTP NHS Trust)
- One consultant focussed on neuro-trauma, the other on spinal and orthopaedic trauma.

2.5 WTE Rehabilitation Coordinators (Band 7)

1 WTE Trauma Physiotherapist

- Band 6 Neurophysiotherapist

2. Summary of Rehabilitation Operational Plan:

1. Every Major Trauma patient to be referred to the Rehabilitation Coordinator by the Acute Care Coordinator, immediately if admitted between 9am – 5pm, or 9am the following day if admitted after 5pm.

2. Administrative staff to enter demographics of every Major Trauma patient onto the Rehabilitation Database. Acute care clinical information sections are automatically populated on the database via linkage with the Acute Care summaries. Rehabilitation Coordinators enter detailed information regarding management plans, including those from acute specialty teams on a day-to-day basis, forming the individual Rehabilitation Prescription for each patient.

3. Every Major Trauma patient to be seen by the Rehabilitation Coordinator within 24 hours of admission on weekdays (maximum 72 hours in case of weekends.) Immediate assessment includes the identification of physical, cognitive and psychosocial factors affecting activities or participation and completion of the TARN minimum dataset.

4. Rehabilitation plan put in place by Rehabilitation Coordinator in collaboration with therapy staff. Plan is communicated to patients and carers, all relevant staff, documented briefly in hospital casenotes and detailed in the Rehabilitation Prescription on the database.

5. A named Rehabilitation Coordinator for each major trauma patient is identified on the database and acts as their Key Worker, coordinating the rehabilitation throughout the admission, liaising with the various clinical teams and communicating regularly with the patients and their families.

6. A named Rehabilitation Consultant is also assigned to each patient on the database. Rehabilitation plans are confirmed by the Rehabilitation Consultant within 24 hours (72 hours after weekends).

7. Multidisciplinary case conference meetings are held weekly for all patients with neurological trauma (Wednesdays) and all with spinal trauma (Fridays). Rehabilitation administrative staff support the Neurotrauma MDT meeting.

8. Case conference outcomes and changes to rehabilitation plans are documented on the Rehabilitation Prescription which is accessible to all the team members in a shared drive on the Trust's IT system.

9. For all patients with brain injury, cognitive screening is undertaken by the Rehabilitation team and referral made to the Neuro-Occupational Therapy team for more detailed assessment. Regular PTA screening is carried out for all patients with post traumatic confusional states and outcomes documented on the Rehabilitation Prescription.

10. If severe neurobehavioural or psychological disorders are identified following initial assessment, referral to the Neuropsychiatry service is made.

11. Therapy staff within RSUH deliver the multidisciplinary rehabilitation defined in the Rehabilitation Prescription, overseen and assisted by the Rehabilitation Coordinator.

12. Rehabilitation Prescriptions are completed by the Rehabilitation Coordinator prior to discharge for all patients. There are two versions:
    a. Core Information: for all patients with non-complex rehabilitation needs
    b. Core + Supplementary Information: For all patients identified as having complex rehabilitation needs, including those requiring specialised inpatient rehabilitation.

The Rehabilitation Prescription serves as the main tool for communication with receiving units in all cases of transfer out of the MTC and allows those units to make appropriate arrangements to receive the patient, supported by the Rehabilitation Coordinator.

13. Consultants in Rehabilitation Medicine contribute to the Rehabilitation Prescription throughout the admission, including regular ward round entries and provide final 'sign-off' upon discharge.

14. Rehabilitation Coordinator attends the weekly MDT referrals meetings at the North Staffordshire Rehabilitation Centre (Haywood Hospital) to facilitate smooth and rapid transfer of patients for inpatient specialist rehabilitation.

15. For those patients requiring specialist inpatient rehabilitation, once the patient is medically stable and appropriate for transfer they will be moved to dedicated beds in the North Staffordshire Rehabilitation Centre (Haywood Hospital) within 24 hours.