UHCW NHS Trust Major Trauma Rehabilitation Pathway.

MTS Inpatient Rehabilitation team:

- Specialist Rehabilitation Medicine Consultants. There is identified Major trauma assessment and review time Monday to Friday.
- 1 WTE Major Trauma Therapy Lead.
- 4 WTE Major Trauma Rehabilitation Co-ordinators.

Major trauma admissions are initially reviewed and their management needs co-ordinated by the acute Trauma Co-ordinators. This is recorded on the UHCW MT database. The database holds information on trauma event, all injuries and current management plans, relevant medical history and the patient's day to day progress. The MT prescription for Rehabilitation is created from the database for patients transferring to other hospitals/ to specialised rehabilitation/ being discharged with ongoing rehabilitation needs.

Following a period of acute medical stabilisation the Trauma co-ordinators hand the case over to the Rehab co-ordinators to oversee with rehabilitation and discharge planning focus. Patients with traumatic SCI are managed from admission by the MT SCI Lead Coordinator with support from the acute and rehab coordinators as required.

Rehabilitation needs evaluation is initiated by the ward Therapy teams (OT/ PT) and overseen by the Rehab co-ordinators. In core major trauma specialty areas the rehabilitation needs evaluation is integrated into the Therapy assessment documents. Completion of evaluation is recorded on the MT database by the coordinators

All patients with traumatic brain injury are managed following a cognitive screening process undertaken by the Psychology/ Occupational therapy teams. PTA screening is carried out for all patients with evidence of post traumatic confusion and outcomes documented in the medical notes. A pragmatic view is taken to the relevance of formal testing in those with a known history of cognitive deficit such as dementia. A limited amount of trauma counselling is available and referrals are facilitated by the Coordinators.

AMHATT (Acute mental health assessment triage team) are available to assess and initiate specialist management of patients demonstrating new psychiatric presentations, neuro behavioural issues, and those with a known mental health conditions that are impacting on their current management.

Patients are identified and timetabled for Rehab Consultant assessment and review by the Rehab co-ordinators. The Rehab co-ordinators are present as required at these reviews to ensure communication of accurate information between clinicians, patient and family.
The Rehabilitation Consultant clinically assesses and advises on the early rehabilitation requirements and follow- up needs of the patient. They assist in identifying appropriate rehabilitation pathways and rehabilitation units to provide this for patients requiring specialist inpatient rehabilitation. In addition the Rehabilitation Consultant has an OPD traumatic brain injury follow up clinic to monitor the recovery of Coventry cases that have not required inpatient specialist rehabilitation

When referring to Specialist rehabilitation services the Rehab co-ordinators send a copy of the rehabilitation prescription via nhs.net. At the point of transfer an up to date copy is sent on to the accepting unit with the transfer documentation.

Patients with spinal cord injury are referred as per the national guidelines and this is facilitated by the acute trauma co-ordinators and the MT SCI Lead Coordinator. Whilst undergoing acute management at UHCW, patient care for this group of patients is directed and documented using the UHCW traumatic spinal cord injury pathway. UHCW NHS Trust is linked to Oswestry Spinal Cord Injury Unit and Stoke Mandeville Spinal Cord Injuries Unit.

For Level 1 rehabilitation the Central England Rehabilitation Unit (CERU) is the primary linked unit for UHCW MTC but other regional unit options include Leicester Brain Injury Unit and the Inpatient Neurological Rehabilitation Unit (Birmingham). If the patient's needs are determined to be Level 2b, Coventry, Nuneaton and Rugby patients are referred to commissioned beds at CERU. All other cases are repatriated for care closer to home at their local TU/LGH with the recommendation they require access to an appropriate locally commissioned 2b rehabilitation service.

As close to the point of discharge to another inpatient medical facility, a specialist rehabilitation unit or into the community with ongoing rehabilitation needs, the Prescription of rehabilitation is finalised and discussed with the patient or family. The patient is given a copy for their records (a second is provided if community discharge so it can be shared with future rehabilitation service providers), a copy placed in the medical notes and a copy sent to the Patient's GP.

UHCW MTC: ACUTE TO SPECIALISED REHABILITATION PATHWAY.