Royal Stoke University Hospital Major Trauma Rehabilitation Team

1. Structure

- 1.5 WTE Consultants in Rehabilitation Medicine
    - From a total of 5 Consultants holding joint appointments at Royal Stoke University Hospital (RSUH, UHNM NHS Trust) and Haywood Hospital (MPFT NHS Foundation Trust)
    - Consultants hold a variety of special interests, including neuro trauma, spasticity, musculoskeletal injury and amputee rehabilitation
    - Daily consultant presence for the on-site Acute Trauma and Rehabilitation Unit (ARTU), established in May, 2016.

- WTE Major Trauma Rehabilitation Coordinators (2 X Band 7, 4 X Band 6)
    - From mixed nursing and allied health professional backgrounds

- Full multi-disciplinary rehabilitation team, with staffing levels as per British Society of Physical and Rehabilitation Medicine (BSPRM) guidelines for specialised rehabilitation, on ARTU.

2. Summary of Rehabilitation Operational Plan:

1. Rehabilitation Coordinator is made aware of every Major Trauma patient immediately if admitted between 9am – 5pm, or 9am the following day if admitted after 5pm.

2. Administrative staff enter demographics of every Major Trauma patient onto the Rehabilitation Database and the Major Trauma Daily Summary. Rehabilitation Coordinators used standardised clinical proformas directly onto the Trust's medical information system (iPortal). They 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 Immediate assessment includes the identification of physical, cognitive and psychosocial factors affecting activities or participation and completion of the NMTD 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.

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 and will assess the patient where there are complex rehabilitation needs.

7. 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. Senior Clinical Psychologists work within the major trauma team and see al identified cases with need for their input. Regular PTA screening is carried out for all patients with post traumatic confusional states and outcomes documented on the Rehabilitation Prescription.

8. If severe neurobehavioural or psychological disorders are identified following initial assessment, referral to the Mental Health Liaison team, or for local patients, the Neuropsychiatry service.

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

10. 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 a tool for communication with receiving units on transfer out of the MTC and allows those units to make appropriate arrangements to receive the patient, supported by the Rehabilitation Coordinator.

11. Consultants in Rehabilitation Medicine are available to support the Rehabilitation Prescriptions and assess all patients identified as having complex rehabilitation needs or requiring inpatient specialised rehabilitation.

12. For those patients requiring specialist inpatient rehabilitation, once the patient is medically stable and appropriate for transfer they will be moved to dedicated beds according to the units' waiting list.

    a. Hyper-acute rehabilitation is provided on ARTU for patients with acute medical needs and who require on-going multi-specialty input
    b. Post-acute rehabilitation is provided nearby in Broadfield Unit, BU, Haywood Hospital, MPFT.

13. Rehabilitation Coordinator contributes to the weekly MDT referrals meetings (ARTU and BU) to facilitate smooth and timely transfer of patients for inpatient specialised rehabilitation.

14. For those patients outside the North West Midlands and North Wales Major Trauma Network, the rehabilitation coordinators liaise with coordinators and / or case managers in the patient's locality to organise onward delivery of the rehabilitation plan.

15. For patients with inpatient specialist rehabilitation needs that cannot be met by the ARTU-BU pathway (e.g. severe behavioural problems or Level 2b rehab needs), the rehabilitation coordinators support the specialty team to make referrals to the relevant ICB leads to secure appropriate placements.

16. 1 to 2 weeks after discharge from the MTC, telephone reviews are conducted by the Rehabilitation Coordinators to identified patients, with their consent, as a follow-up to ensure the plans described in the rehabilitation prescription are underway and to troubleshoot any unexpected issues after discharge.

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