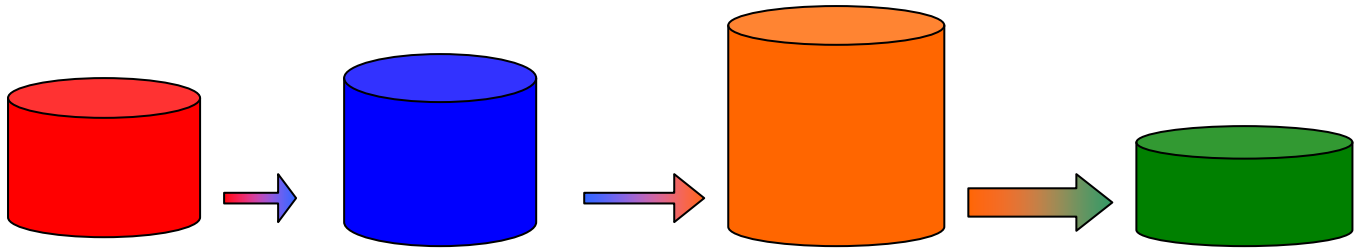
Salisbury NHS Foundation Trust

PHASE 4

REHABILITATION MILESTONES

The Multidisciplinary Staff of the Spinal Treatment Centre have created a Rehabilitation Milestone guide for all patients admitted to the Centre.

There are 4 Rehabilitation Phases:-



Phase 1
Post - admission to mobilisation

Phase 2
Mobilising up to 4 hours per day

Phase 3
Up for 4 hours per day to 2 weeks before discharge

Phase 4
The 2 weeks running up to discharge and on discharge

Each patient on admission is given a copy of the Rehabilitation Milestones. This informs the patient about the Phases of Rehabilitation and what he/she can expect from the Multidisciplinary Team, within each phase, working towards their discharge. There is also a copy of the Rehabilitation Milestones on each Ward Notice Board. Throughout the patient's stay he/she is encouraged to participate in planning and reviewing his/her goals of rehabilitation. At the patient's Goal Planning Meetings realistic, timely goals are set, in conjunction with the phase of rehabilitation that he/she is in. Goals are set to be worked towards and achieved prior to the next meeting, 4 weeks later.

What can be expected?

PHASE 4 The 2 weeks running up to discharge and on discharge

This is the final phase of the patient's rehabilitation, when many patients are anxious about leaving the supportive environment of the Spinal Centre. Psychological monitoring and support during this last phase is continued.

Final reviews are undertaken by the medical staff, with an assessment of the patient's health status and medication. The patient's neurological level is reviewed to assess functional ability on discharge. Medication (known as TTOs) to take home is prescribed and an electronic discharge summary for the patient's GP is completed.

If the patient needs long-term ventilation the Respiratory Specialist will have written to the patient's local Ambulance Service, Anaesthetist, Chest Physician and Ear Nose and Throat Consultant, telling them of the patient's presence in the community and what emergency plans are in place. Final assessment will be undertaken during this time to ascertain the patient's discharge status, such as their vital capacity, and to ensure goals have been achieved. Training will be completed and there will be a hand-over of physiotherapy care to the care team in the community.

Nursing goals will be evaluated with the patient. A discharge checklist will be completed before discharge to ensure the patient has all the information he/she needs regarding equipment. The nursing communication, outlining care, to the District Nurse has been completed, as well as completion of the electronic discharge summary. The nurses will also ensure that TTOs (for 7 days) are available to take home as well as interim equipment.

A discharge appointment is undertaken with the Pressure Clinic staff, this is to ensure the patient has all the information and advice he/she needs for discharge as well as information about the follow up plans, and attendance at the Outpatient Clinic. Community Liaison staff, who visit the patient in the community, will introduce themselves and identify arrangements for their visit.

If the patient is to be rehoused a home visit might have to be undertaken during this time. The therapists will complete a transfer and discharge summary and identify how the patient can achieve self-sustaining levels of function.

The Discharge Co-ordinator and her deputy will finalise arrangements, check that equipment has been delivered and that the care package will be in place following discharge. Most importantly, they will ensure that the patient has a safe transfer to his/her discharge destination.