Spinal Pathway

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1. PURPOSE

This document is intended to provide clear guidance for staff and managers at the spinal centre and others about the processes relating to the patient journey through the Spinal service.

2. INTRODUCTION

This document describes the processes and responsibilities associated with the Spinal Cord Injury (SCI) pathway at the Salisbury Spinal Centre, including referral, acute admission for first episode of rehabilitation, other admission pathways, discharge and lifelong follow up.

3. SCOPE

An outline of the whole pathway, with target timescales where appropriate is given here, with reference to relevant specific Standard Operating Procedures and the Rehabilitation Milestones document, where more details regarding various aspects of the pathway are available. Please see section 7 for details.

4. DEFINITIONS

Definition of Spinal Cord Injury (*from **D13/S/a NHS STANDARD CONTRACT FOR SPINAL CORD INJURIES (ALL AGES)**)*

Specialised spinal cord injuries encompass any traumatic insult to the spinal column at cervical (neck), thoracic (chest), thoracolumbar, lumbar, lumbo-sacral (lower back) or multiple levels which causes complete or partial interruption of spinal cord function.

For the avoidance of doubt, Specialised SCI Services include patients who have experienced Spinal Cord Injury resulting either from a traumatic cause or a non- traumatic cause.

Explanatory Note: When such injury results from an accident such as a road traffic accident or a fall it is referred to as “traumatic” SCI. When it results from disease or infection it is referred to as a “non-traumatic” SCI

5. RESPONSIBILITIES

Clinical leadership	Clinical Lead
Overall management across the centre	Specialty Manager
Nursing leadership	Matron
Therapy leadership	Therapy Lead
Ward management	Ward Lead
Out-patient nursing	OP Clinical Nurse Specialist
Acute Outreach	CNS Outreach Lead
Admin leadership/resource management	Resource Co-ordinator
Discharge processes	Discharge Co-ordinator
Clinical Psychology	Clinical Psychologist
Clinical Responsibility for patients’ medical management and rehabilitation	Spinal Consultants

6. SPECIFIC PROCEDURE

6.1 Acute Outreach Processes

Patients are referred by major trauma centres in Southampton, Bristol and Plymouth and other hospitals within the catchment area. Both online and telephone referrals are required.

Once referral status is confirmed, a member of the Acute Outreach team will contact referrers within 2 working days of receipt of the referral.

Criteria for acceptance (see referral and preadmission process SOP) applied in daily (Monday – Friday) discussions with Spinal Consultants.

Updates are taken regularly by the Acute Outreach team in the case that patients are not fit for admission.

When fit for admission and bed availability identified, admission arranged.

Acute Outreach team also continuously consider the need for the input of Spinal Centre and other Salisbury District Hospital staff in the admission process and advise teams in referring hospitals regarding the care of patients with Spinal Cord Injury who are awaiting admission, or whose discharge is planned without admission to the Spinal Centre.

6.2 South West Regional SCI Network

All SCI patients in the catchment area of Salisbury SCI centre will have access to support from the South West SCI Operational Delivery Network teams. Clinicians based in each of the 3 major trauma network footprints (Wessex, Severn and Peninsula) and resources for psychological support covering the entire region will be available regardless of geographical location or care pathway (e.g. whilst awaiting transfer to the SCIC, whilst undergoing care or rehabilitation in a different location, or in the community).

This will complement, not duplicate or replace the Acute Outreach or services described in this SOP and aim to bring SCI expertise closer to patients as part of an integrated approach supporting SCI patients and those caring for them.

6.3 Admission Processes

On arrival of the patient in the Centre, the receiving Consultant will confirm the appropriate method for transferring the patient in to the bed.

A provisional EDD will be allocated on admission.

Clerking is undertaken by ward doctor, including admission ASIA.

Accepting Consultant reviews, confirming level of injury and any precautions/restrictions to care or therapy.

Initial Physiotherapy assessments, including respiratory function are carried out by a Physiotherapist on day of admission if possible, or at least within 24 hours.

Nursing assessment completed within 6 hours

Occupational therapy (OT) initial assessments and assistance to set up complex nurse call solutions if needed within 48 hours.

Named nurse allocated within 24 hours of admission.

Primary OT and Physiotherapist allocated within 24 hours of admission.

Patient measured and wheelchair and cushion from the Centre's rehabilitation stock for initial mobilisation are identified on day of admission if possible or at least within 24 hours.

All patients for whom there are no contraindications are mobilised into a wheelchair within 24 hours.

The protocol for the length of time of the initial mobilisation and subsequent schedule of increasing times on a daily basis is determined by the Nurse in charge and Pressure Clinic.

First mobilisation is carried out by therapists, with involvement of other roles (e.g. rehab Engineer, Pressure Clinic) according to their clinical judgement.

6.4 First Episode of Rehabilitation Processes

"The aim of rehabilitation is that the patient achieves their potential or is in a position to progress effectively towards it with available post-discharge services" (Spinal Cord injury Clinical Network Standards of Care - Rehabilitation during first Admission (2022) and this is achieved through a multi-disciplinary approach in the SCI centre, guided by these standards.

6.5 Discharge

Overall responsibility for discharge arrangements lies with DISCO. They meet each patient within 5 days of admission and manage all liaison regarding discharge, including notifications required to CCGs, Social services, Housing providers etc. (see Rehab Milestones for details).

When all goals essential for discharge are achieved patients are discharged, provided that a suitable discharge destination and all of the essential equipment and support are available.

If a patient is not medically fit, or has outstanding rehabilitation goals essential for discharge outstanding, the EDD will be extended if agreed by the MDT.

If goals are complete and the patient is medically fit, but there are delays due to the availability of equipment or support.

At discharge the DISCO ensures the Safe Discharge Checklist is signed off and arranges transport if required.

Medical, Nursing and Therapy staff complete the Electronic Discharge Summary on the day of discharge and ensure TTOs ready.

6.7 Alternative admission pathways

6.7.1 Short Stay Assessment Admission (SSA)

This is for assessment purposes only and is not intended to provide rehabilitation. The spinal team will provide recommendations to the G.P., district nurses and community therapists as appropriate based on the outcome of these assessments.

If further rehabilitation goals are identified by the spinal team during the admission, then the patient will be offered the opportunity to return Second Stage Rehabilitation (see below).

Criteria: Patients must fulfil criteria for admission and non-acceptance and they will have been discharged out of hospital to a suitable placement for subsequent discharge following their SSA admission. These patients may have limited rehabilitation goals, or due to complex additional comorbidities would be unsuitable for intensive inpatient rehabilitation.

6.7.2 Second stage rehabilitation (SSR)

Sometimes during their first episode of rehabilitation patients reach a plateau whereby there are still outstanding rehabilitation goals, but they are not able to be achieved in a timely way. This may, for example, be due to ongoing medical precautions/restrictions, risks to skin integrity, or the need for strengthening before progression can be made. In this situation the SSR can be used.

This consists of early discharge (provided a suitable discharge destination is available) with a plan for re-admission for an agreed period at the appropriate time for the patient to complete their goals with the required support. This is potentially repeatable if indicated clinically and is also available to SSA patients or Out-patients for whom active goals have been identified.

6.8 Lifelong follow up processes

All patients discharged or referred for review by the Spinal Centre will receive life-time follow-up from the multidisciplinary team.

The schedule for review of patients is as follows:

1. At 12 weeks post-discharge - Discharge Review Clinic appointment with Clinical Nurse Specialist (CNS). Following this appointment the Clinical Nurse Specialist will complete an outcome form which will identify when the patient is next due a review appointment and who can see the patient at the next appointment i.e. Clinical Nurse Specialist or Consultant
2. 12 months post-discharge – Consultant/CNS review, including renal ultrasound and abdominal x-ray (if required). Following this appointment the Consultant/CNS

will complete an outcome form which will identify when the patient is next due a review appointment and who can see the patient at the next appointment i.e. Clinical Nurse Specialist or Consultant

3. At future review appointments the Consultant or Clinical Nurse Specialist will identify when the patient should be reviewed again. Subsequent review is based upon medical/clinical individual assessment of the patient and will be no greater than 2 years
4. NB. All patients with a history of renal stones, bladder stones, hydronephrosis, single kidney, reflux and those managing their bladder with condom drainage should be reviewed annually

In addition to the review appointments described above, the following services are also provided, if indicated, on an out-patient basis by the Spinal service

- Intrathecal drug delivery system refill service
- Sexual function/fertility service
- Out-patient therapy service
- Orthotics service
- Video-urodynamic service
- Posture & Seating service
- Bowel management service
- Community Liaison service

All of these services are provided on an “as required” basis, rather than as part of an overall review framework. Needs for these services are identified at scheduled review appointments, triggered by referral from patients’ GPs, other healthcare professionals or by patients contacting the service direct.

Subject to triage by the most appropriate members of the out-patient team, interventions and advice are offered in the most suitable format, which may include face to face appointment at the Centre, telephone or Skype interview or email.

7 Outcome Measures:

Spinal Cord Independence Measure (SCIM)
SCIM will be carried out with outpatients either during a telephone call, when they attend their review appointment, or if seen in the community. SCIM will be scheduled and carried out by the Out-patient team with patients at the following times:

- 6 months post-injury (if an outpatient)
- 12months post-injury
- 24 months post-injury

American Spinal Injury Association (ASIA) Impairment Scale
ASIA will be carried out with outpatients when they attend their review appointment. ASIA will be scheduled and carried out by a member of the clinical team at the following times:

- 6 months post-injury (if an outpatient)
- 12months post-injury
- 24 months post-injury

Craig Handicap Assessment & reporting Technique (CHART)
CHART will be carried out with outpatients by outpatient nursing staff at the following times:

- 2 years post-injury
- 5 years post-injury

7. REFERENCES

1. *Standards for Adults Requiring Spinal Cord Injury Care. Approved by the Spinal Cord Injury Clinical reference Group, 19th November 2013.*
2. National Standards for Specialist Rehabilitation of Spinal Cord Injury (2022) https://www.bsprm.org.uk/wp-content/uploads/2022/10/SCI-Rehab-standards.pdf

Standards for
Specialist Rehabilita

7.3 *Glossary*

Acute Outreach team - Team of specialist nurses (with input from other disciplines as required) with responsibility of managing the new referrals to the Spinal service, visiting newly referred patients and arranging admissions.

ADL flat – Accommodation adjacent to the therapy areas, providing a simulated domestic environment, with opportunities to assess and practice daily living skills, including trial overnight or weekend stays in preparation for discharge.

Autonomic Dysreflexia - a syndrome in which there is a sudden onset of excessively high blood pressure. It is more common in people with spinal cord injuries that involve the thoracic nerves of the spine or above (T6 or above).

CCG – Clinical Commissioning Group. Commissioners of non-specialist NHS services for local areas.

Community Liaison – A clinical nurse specialist-run service supporting SCI patients in the community.

DMT – Directorate Management Team. The spinal service is managed by the Musculoskeletal Clinical Director, Directorate Manager, Directorate Senior Nurse and supporting team.

EDD – Estimated date of discharge

National SCI Database – All referrals to Spinal Centres are made, managed and monitored through the national database.

Pressure Clinic – A specialist Technician-led service in the spinal centre, assessing pressure risk for all patients and recommending interventions to minimise the risk.

TTO – To Take Out. A common medical term for medicines prescribed and provided for discharge.

VUD – Video Urodynamics. The study of pressure and flow in the lower urinary tract.

8. CHANGE HISTORY

SOP no.	Effective Date	Significant Changes	Previous SOP no.
V 01	March 2023	First version	-
V 02	Nov 2025	Reviewed as part of Flow Project	V 01