GM NR Addendums to the NHS England Best Practice Standards for NeuroRehabilitation

1. Standards for Neuro-Rehabilitation

1.1 Patients will be admitted/ received from health or social care professionals as per the service referral protocol.

1.2 All assessments are carried out by an appropriately skilled nurse and/or therapist, supported by consultants in neurorehabilitation/rehabilitation medicine, for management of referrals, assessments and admission.

1.3 The rehabilitation team should comprise of Consultant(s) in rehabilitation medicine, Specialist Nurse, Physiotherapists, Occupational Therapists, Speech and language therapists, Dietician, Clinical Psychologist, Discharge Coordinator, and meet agreed staffing levels (RAG1 or 2 ratio).

1.4 All patients are required to have a discharge plan, which includes a discharge opinion on clinical readiness, rehabilitation needs, category for a 8 weeks trial and risk assessment if not dependent on supervision needs; there should not be a gap or number of patients requiring 11-11 supervision.

1.5 Patients are under the direct care of a Consultant in Neurorehabilitation Medicine.

1.6 Patients are discussed as early as possible in Single Point of Access (SPA), within 4 working days following initial assessment (Applicable to all services excluding hyper-acute).

1.7 Outcome of NDT discussion coordinated to refer to the same day of taking decision; decision to accept patient and add to waiting list or provide a resource/alternative when not accepted.

1.8 Initial referral to neurology at the earliest opportunity and postural advice when indicated.

1.9 The service should have access to all co-dependent services as identified and defined in the Neuro Rehabilitation Co-Dependency Framework.

1.10 The service should have open access to an administrative body which regulates the service, their care, goal setting principles, rehabilitation and discharge process.

1.11 All patients must be assessed by a Doctor within 6 hours.

1.12 Immediate nursing assessments will be completed within 4 hours of admission with regard to swallowing, positioning, moving and handling, bladder and bowel control, tissue viability, communication, nutritional status and risk.

1.13 Patients on established enteral feeding will be handed over to the named service dietician prior to patients being transferred to the service.

1.14 Patients on established enteral feeding will be reviewed by a dietician on Day 1 of Admission.

1.15 Patients will be assessed by Dietician within 3 working days of a referral/cohort pathway.

1.16 Patients must be screened by a speech and language therapist within 5 working days of referral.

1.17 Referral to social work received within 7 days. (Consulting by Neuropsychology for GP).

1.18 Admission (ARMS) data will be completed within 7 days of admission.

1.19 Outreach planning will commence on admission, supported through strong working relationship with the Complex Discharge Team/Community Neuro Rehabilitation Team/Social Service Department, as per the structural standards documentation.

1.20 Structured rehabilitation programmes will be provided to meet the needs of the patient 7 days per week.

1.21 Every patient should be discussed by the MDT at least weekly. (Not necessary for Slow Stream).

1.22 The MDT meetings must be cross-functional throughout the year (and take place even though the Consultant is not present).

1.23 All Weekly Fall planning taken place.

1.24 Rehabilitation will be provided to meet patient-centred goals and monitored using agreed outcome measures.

1.25 Pain/physical examination results will be used where possible (for example, patients/family education survey) to ensure that patients are satisfied with the care and understand the benefits of the rehabilitation package.

1.26 Where possible, in patient neuro-rehabilitation services will engage in self-care evaluation and self-management care as far as possible e.g. going out activities of daily living, self-medication.

1.27 Where possible, neuro-rehabilitation services to provide appropriate treatment to patient the development of secondary problems.

1.28 Where possible, neuro-rehabilitation services to provide patient self-care evaluation and self-management care as far as possible e.g. going out activities of daily living, self-medication.

1.29 Neuro-rehabilitation services will ensure that patients access appropriate counselling and psychological services to enhance quality of life.

1.30 Advanced planning will take place for patients where further recovery is not anticipated (poor prognosis and / or limited life expectancy).

1.31 No patients who are in the last 6 days of life should be referred to palliative care services to care is ensured to be co-ordinated and delivered in accordance with their personal care plan.

1.32 Care management is completed during initial assessment and on transfer: Factors directly related to all conditions will be identified and strategies put in place to decrease future risk.

1.33 Patients with challenging behaviours are supported such that the risk to themselves or other patients, visitors, staff and facility is minimised.

1.34 All the Neuro-Rehabilitation services will embed the complex discharge team within the multi-disciplinary team to facilitate the patient pathway.

1.35 There is a discharge standard operating procedure, which includes assessment of the environment & graded discharge where clinically indicated.

1.36 Referrals will be received from health or social care professionals as per the service referral protocol.

1.37 Teams and services are actively involved in the transfer/discharge process whenever possible.

1.38 Patients will be given a satisfaction survey close to the time of discharge.

1.39 On discharge, patients/relatives will be provided with discharge information including a summary of their progress within the service, ongoing self-management advice/choices (when applicable) and information about other services e.g. any services the patient is being referred onto (ascertainment of any voluntary sector support/alternatives etc).

1.40 Co-ordination of delayed discharges will be monitored on acute trust 'Situation Reports (SIT REP)' to ensure links with the scheduled care lead for each CCG, or escalated to the CCG Director.

1.41 The clinical team should consult with the Complex Discharge Team, Community Neuro Rehabilitation Team/Social Service Department, if the patient has delayed discharge.

1.42 Access to appropriate therapy environments for Physiotherapy, Speech and Language Therapy, Occupational Therapy, Social Work.

1.43 Access appropriate, access to kitchen areas for therapists/assessment and treatment.

1.44 Access to communal areas for social and other group sessions.

1.45 Access to rooms for individual assessment will be provided.

1.46 Access appropriate, to communication aids.

1.47 Access to specialist training for 홀화mathrm rehabilitation.

1.48 Access to common spaces for therapy sessions.

1.49 Where appropriate, access to leisure activities which enhance rehabilitation, for example; music groups, news groups, games, pools, outdoor activities such as gardening.

1.50 Midweek goal planning taken place using interdisciplinary team.

1.51 Trust should have time allocated in their job plans to complete assessment of referrals as described in the ODN's Preadmission Process.

1.52 Referrals will be received from health or social care professionals as per the service referral protocol.

1.53 Access to gym space for therapy sessions.

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1.58 Access to common spaces for therapy sessions.

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1.60 Midweek goal planning taken place using interdisciplinary team.

1.61 Trust should have time allocated in their job plans to complete assessment of referrals as described in the ODN's Preadmission Process.

1.62 Patients and families should have access to high quality information about their condition, management and wider social inclusion issues.

1.63 Consultants should have time allocated in their job plans to complete assessment of referrals as described in the ODN's Preadmission Process.

1.64 Access appropriate, access to kitchen areas for therapists/assessment and treatment.

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4. Post Acute Tracker

The service must have the competencies, skills and experience level to meet and manage the specialist needs of patients with a Tracheostomy including weaning from a tracheostomy and respiratory management.

4.2 The clinical team should include the appropriate skills and experience level for weaning and decannulation purposes: access to HTS (Throat Tracheal Stomal Evaluation of Dysphagia) & physiotherapists & speech & language therapists trained in tracheostomy management.

4.4 Ability to deliver slow weaning programme & weanable rehabilitation.

4.5 Estimated length of stay will be identified following assessments and the expected date of discharge will be shared with patients, families and social service colleagues within 12 weeks of admission.

4.6 Where appropriate, single rooms must be provided for Tracheostomy patients (based upon clinical reasoning).

4.7 Adequate room size and bed space to allow storage of supporting equipment related to patients e.g. tracheostomy box, and using other equipment e.g. hoist.

4.8 Patient and family (wherever possible) case conference should be organised and admission within 6 weeks following a patient’s admission. The meeting should be chaired by a consultant, nurse or AHP and any notes discussed documented. Follow up family case conference meetings should be set for AGD.

4.9 Estimated timescale for length of stay will be discussed with the patient/family/NMP prior to admission to the service for those patients who access the service from the community.

4.10 As per the GMNR ODN acute care pathway, patients must be screened by a speech and language therapist within 5 working days of referral. Dietetics must assess the patient within 5 working days of referral.

5. Fast Acute

5.1.1 Adequate appropriate space to assess patient referral within 3 working days of admission.

5.1.2 Clinical assessment is performed and patient’s eligibility for admission to service is determined.

5.1.3 Clinical advice is given to managing team.

5.1.4 Documentation in patient notes is appropriate.

5.1.5 Assessment is completed.

5.1.6 NPDS is completed.

5.1.7 Patient’s communication tool is completed.

5.1.8 Information is given to patient/family as appropriate.

5.1.9 Estimated average length of stay 61 days.

5.1.10 Patient goals must be set by the MDT, in conjunction with the patient/family whenever possible, within 2 weeks of patient admission and reviewed fortnightly.

5.1.11 Estimated average length of stay 67 days.

5.1.12 Patient goals should be reviewed by a consultant a minimum of once weekly 52 weeks per annum.

6. Slow Stream

6.1.1 Airway and oropharyngeal rehabilitation, a consultant led service will be provided with minimum attendance of once per month and supported with primary care input.

6.1.2 Consultations will be held with the patient, relevant MDT members and family members within 2 weeks of admission if not already in place 6 weeks.

6.1.3 The service must have the competencies, skills and experience level to meet and manage the specialist needs of patients with PDCC.

6.1.4 The service must have an MDT approach to PDCC and comply with policies to support these aspects of care.

6.1.5 Estimated average length of stay will be identified following assessments and the expected date of discharge will be shared with families and social service colleagues within 6 to 12 weeks of admission.

6.1.6 Estimated timescale for length of stay will be discussed with the patient/family/NMP prior to admission to the service for those patients who access the service from the community.