# South East London Neurorehabilitation Service

# Service Specification and Admission Criteria

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| Name of units | Ontario Ward, King’s College Hospital NHS Foundation Trust and Pulross Ward, Guy’s and St Thomas’ NHS Foundation Trust |
| Location / contact | 1st floor, Orpington Hospital, Sevenoaks Road, Orpington, Kent BR6 9JU  Tel:01689 866284  Pulross Centre, 47a Pulross Road, Brixton, London, SW9 8AE  Email: [kch-tr.SELNSreferrals@nhs.net](mailto:kch-tr.SELNSreferrals@nhs.net) |
| Main groups treated | Patients aged 18 and over (or patients aged 16-18 subject to discussion with local paediatric teams) who are registered with GPs from the boroughs of Lambeth, Southwark, Lewisham, Greenwich, Bexley or Bromley who are recovering from the following organic neurological conditions:   * Acquired brain injury of any cause. * Incomplete cervical spinal cord lesions, and incomplete or complete thoracic or lumbar spinal cord lesions (of any cause), if a referral to a Regional Spinal Cord Injuries Centre (RSCIC) has been made but access is delayed, or if they have been declined. * Peripheral neuromuscular disease e.g. Guillain Barré syndrome, critical illness neuropathy, polymyositis. * Complex polytrauma where brain injury is the predominant presentation * Patients requiring complex spasticity management * Patients with neurodegenerative disorders (e.g. multiple sclerosis, parkinson’s Disease etc) requiring specialist rehabilitation * If not registered with a GP, residential address will be taken as the default borough Patients will be referred to Ontario or Pulross depending on clinical need. Where possible, patient preference will be taken into consideration. |
| Primary service description | Post-acute specialist level 2B in-patient neurological rehabilitation for patients recovering from acquired disability.  **This 2B service is split across two sites with 14 beds sited at Ontario ward in Orpington hospital and 6 beds at Pulross Centre in Brixton.**    These patients will require multidisciplinary inpatient neurorehabilitation by a team trained in specialist rehabilitation led by or supported by a consultant trained and accredited in rehabilitation medicine.  These patients will require 2 or more intensive therapy disciplines and usually require specialist equipment to support recovery. This may include assistive technology, specialist seating and bespoke orthotics.  The team comprises Consultants in Rehabilitation Medicine, Consultant therapist in neuro-rehabilitation, nursing, physiotherapy, occupational therapy, speech and language therapy, psychology, specialist social worker and administrative staff.  Specialist spasticity services including the regional baclofen clinic, orthotic service and rehabilitation assessment clinics are also offered. |
| Inclusion Criteria  Rehab Criteria | Evidence of progress towards attainment of identified goals, with a reasonable expectation of increased personal independence and participation in roles  Ability to follow direction/ instruction  Ability to learn, and retain learning, with evidence of transfer of knowledge  Patient motivation and participation  A capacity assessment and if indicated a best interest meeting regarding transfer to inpatient rehabilitation has been completed.  Ability to tolerate high intensity rehabilitation e.g. at least 45 minutes of each relevant therapy session daily  Sitting tolerance of at least 1 hour  (Patients with pressure sores greater than Grade 2 will not be admitted, depending on the functional impact of the position of the sore)  Stable medical condition, to allow continued participation in the rehabilitation program.  Requires intense input from 2-4 therapy disciplines, in an inpatient setting.  It is anticipated that a period of inpatient rehabilitation will reduce the current level of dependency  The referral team have identified if a patient has recourse to public funds |
| Exclusion criteria | The unit does not accept   * Patients who are ineligible to receive NHS-funded rehabilitation care * Patients whose GPs are outside the CCGs areas named above * Patients who do not meet the Rehab criteria (above) * Patients whose current rehab goals/needs will be best met in alternate/community setting * Persistent Vegetative States and Minimally Responsive States (RHND Putney) * Severe behavioural problems which could not be managed in this environment Patients treated under the Mental Health Act (BBIRU) * Patients requiring suctioning or tracheostomy care * Patients who do not to consent to a referral being to SELNS and have mental capacity to make this decision. Those lacking mental capacity to make this decision will be treated under DOLS. * Patients with pressure sores greater than Grade 2 depending on the impact on function. * Patients unable to weight bear due healing fractures depending on the functional impact on their rehabilitation. * Patients with NG tubes are not accepted at Pulross Centre. * Patients with NG tubes will only be accepted to Ontario with a documented plan for removal or conversion to PEG/RIG feeding * PICC lines are not routinely accepted but each case can be discussed on its own merits with the accepting unit. * Those requiring 1:1 nursing for their own safety e.g. as a result of severe cognitive difficulties Patients with Functional Neurological Disorders or where the functional component of their presentation predominates. |
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| Capacity | Total 20 beds  **14 beds sited at Ontario ward in Orpington hospital and 6 beds at Pulross Centre in Brixton.** |
| Mean in-patient LOS | Typically >6 weeks |
| Features of the service in relation to service specification standards | * Inter-disciplinary programme with agreed short- and long-term goals, (which are patient-led , wherever possible) * Goals are set within 2 weeks of admissions and reviewed at two-weekly intervals. * Access to early prosthetic and orthotic assessment via outpatient clinic * Discharge planning starts from point of admission involving Specialist social worker, Neuro navigators, pathway coordinators, social services, CCGS, housing and relevant community rehabilitation and care teams * Preparation for discharge may include graded exposure to the community, for example weekend leave. * Family and carer support offered as an integral part of the programme * A key-worker is allocated to each patient to act as a case co-ordinator. * Specialist equipment funding requirements are addressed, and negotiated with the patient’s local CCG or social services as necessary * A family meeting is held within 2 weeks of admission to discuss likely outcomes, discharge destination etc. and after that on a regular basis. * Written information is provided to patient and family before and during stay * A discharge summary and care plan are given to patient and family |
| Waiting time for admission | All referrals will be triaged within 2 working days and an assessment offered if appropriate.  We will endeavour to admit patients within 2 weeks of acceptance and will provide fortnightly updates to referrers on estimated dates of admission |
| Main outcome measures recorded | * UKROC data set for 2b service including UK FIM+FAM (Functional Independence measure and Functional Assessment Measure) * Rehabilitation Complexity Scale * Mayo- Portland Adaptability Inventory and other measures as clinically appropriate |
| Other reported outcomes | * Patient destination on discharge: Home No therapy; Home level 3 therapy, Home Enhanced Therapy, Acute Hospital, Specialist Rehab Unit, Other * Length of Stay * Patient/family feedback questionnaire reported using local Trust satisfaction surveys (with the intent to develop a shared rehabilitation-specific questionnaire) * Referrer satisfaction rating reported quarterly * Adverse incidents and ‘near miss’ register * Record of plaudits and complaints |
| Audit and Clinical governance | * All staff participate in yearly appraisal and objective setting and monitoring * Rolling audit of outcomes and patient and referrer satisfaction feedback |