Buckinghamshire Healthcare NHS
NHS Trust

The National Spinal Injuries Centre- Scope of Practice

The National Spinal Cord Injury Centre (NSIC) at Stoke Mandeville Hospital provides specialised, coordinated, interdisciplinary, medical and rehabilitation care which is outcome focused and patient centred serving the unique needs of people with spinal cord dysfunction. The service is needs based and not age discriminatory. There is a total of 114 beds for people with spinal cord injury, 62 of these are for active rehabilitation, and there is a dedicated young person's rehabilitation unit of 9 beds for spinal cord injured young people. The remaining beds are for acute admissions or people who are medically unstable and secondary elective admissions. There is a dedicated workstream to address the specific needs of the older adult.

Mission:

The NSIC assists people with limitations secondary to spinal cord injury or paralysis, of all ages, to achieve realistic goals and to reach their highest feasible level of functioning by providing a comprehensive, specialised, interdisciplinary rehabilitation service across their lifespan. This provides them with the skills, knowledge and information for them to return to their role in society and achieve participatory goals.

Vision:

The NSIC strives to champion and respond to the needs of all people with spinal cord impairment, who need rehabilitation throughout childhood and adolescence and transition into adult spinal services.

We are committed to working with charitable and statutory organisations to promote a continuum of rehabilitative care through the delivery of high quality spinal rehabilitation services, education, and integrative sports and arts programmes.

Research and post graduate education has an existing and developing role in ensuring the NSIC is at the forefront of knowledge and strives for translational activity in these fields.

Values:

The NSIC is committed to the 5 patient promises of the Buckinghamshire Healthcare NHS Trust.

These are:

1. Clean and safe practice, clinics and hospitals so you never need to worry unduly
2. A caring, helpful and respectful attitude from approachable teams, who listen to you, involve you in decisions about your care and ensure you are clear about what to expect.
3. Respect for your time with care closer to home, offering choice and flexibility with a minimum of delays and cancellations
4. Easy access to comfortable and modern facilities, offering privacy and dignity, personal space and good healthy food.
5. The best clinical care from teams of skilled healthcare professionals, who help you improve and maintain your health.

There is also a set of service standards that the staff are expected to embed into their working practice for communication between themselves, patients and staff. These are under the main headings of communication, compassion and courtesy.

We strive to be good stewards of the finances available to the service, whether as part of the contracts or donations.

Spinal System of Care:

The goal of the Spinal Cord Programme is to provide culturally sensitive, comprehensive, individualised, goal directed, inpatient rehabilitation services to individuals who have experienced a spinal cord injury or disease and have physical impairments or activity limitations that may potentially benefit from comprehensive rehabilitation programmes throughout childhood until transition to an adult service.

The aim of the programme is to assist individuals to live within their community at their highest level of function both as child or adolescent and in adulthood.

The Spinal Cord Programme endeavours to work toward optimal effectiveness, and achieve a high level of satisfaction to users of the service, their friends and family, by providing appropriate resources as a means to work towards each individual's goals. The service uses appropriate satisfaction measures for adults and young people.

Funding Sources:

The programme is largely funded by National Health Service (NHS) sources. Other third party payment sources are accepted where there are financial agreements within the NHS Trust.

Referral

Referrals are largely from Major Trauma Centres (MTC's), and other general hospitals within the catchment area; the NSIC is linked to 6 MTC's. If patients are unable to be admitted straight from the MTC they may transfer to a local hospital close to them before being admitted to the NSIC. The referral process is via a database specific to the 8 specialist

spinal cord injury centres (SCIC) in England, and the referral is accepted via this route. The referring centre may also contact the SCIC.

Admission Criteria / Types Of Individuals Served:

It is the policy of the NSIC to review the criteria developed by NHS England Commissioning Board, previously the South East Consortium, for admission to, continued stay, and discharge from the programme. Variations from these criteria can be considered, but must be supported by appropriate rationale and goals that are consistent with NSIC's mission, vision, and values. Each individual must require and benefit from a rehabilitative hospital level of care coordinated by a rehabilitation team which includes: 24 hour availability of registered nursing; an appropriately intense level of interdisciplinary services with the intent/ability to achieve realistic functional goals. Patients can be referred with traumatic or non traumatic SCI, and may have a dual diagnosis, e.g. acquired brain injury, as long as the programme is equipped to address the presenting issues. Generally, the appropriate rehabilitation destination will be decided by the extent of the condition requiring priority. Once an individual no longer requires or can benefit from the level of care being provided, they will be discharged or transferred to the next appropriate destination. Progress will be monitored every 3-4 weeks through the established Goal Planning Process.

An individual who is ventilator dependent can be considered for admission for rehabilitation and training. There is a multidisciplinary outreach team who are a link between the referral and admission who can advise and offer support to the person, their family and treating staff.

As admission is needs based there may be individuals with psychological, cognitive or social challenges. Appropriate assessment will be made for these people and they will be admitted to address their Spinal Cord Injury needs if these can be met.

Readmissions for short stay programmes are available for those with identified goals where they cannot access services locally but are expected to benefit from further therapies such as intensive gait training or further management of their personal care. Such patients, have the potential for realistic improvement from this programme as demonstrated and documented by goals with associated time frames, and who are able to manage with medical supervision weekly, or less frequent basis, and who may require nursing care.

Other admissions will be made to the service to address secondary complications such as tissue viability, urology or spasticity management.

Ages Served:

Persons of all ages up to the end of the 18th year can be served by St Francis Ward young person's service, and in the adult service be needs led, not age discriminatory. With older people it is important to establish the most appropriate approach to their needs, from a medical, rehabilitative and geographical perspective.

Medical Acuity:

Individuals who have sustained a disabling condition of recent onset, exacerbation of a pre-existing condition, or in need of a treatment programme designed to lessen disability or dependencies, and are likely to benefit from a comprehensive rehabilitation programme, can be admitted. Individuals must require the availability of 24 hour rehabilitation nursing care, the availability of various ancillary and diagnostic services, and medical supervision. The use of mechanical ventilation equipment is not a contraindication for this service.

Medical Stability:

Individuals must be orthopaedically and haemodynamically stabilised and able to participate in, and benefit from, an intensive rehabilitation programme.

· Patients are admitted to the programme by a qualified Spinal Cord Injury Specialist.

· Patients have access to a broad range of medical specialties and subspecialties to meet all acute care needs.

Hours of Operation and types of programmes:

Inpatient Programme: The inpatient wards provide a rehabilitation environment 24 hours a day, seven days a week. Regular scheduled rehabilitation therapy sessions occur Monday through to Friday with weekends directed to the practice of rehabilitation skills. The patients and the rehabilitation team are encouraged to set home or leisure rehabilitation goals if they are away over a weekend. The young person's service is currently available Monday to Friday evening (8pm) due to staffing restrictions, but they are set active goals to achieve during the weekend. It is planned for this to return to 7 day activity as soon as possible. The interdisciplinary programme ensures an average of 15 hrs of rehabilitation activity daily during the Monday to Friday week.

Review Programme:

Patients receive life long care from the centre once they have made a transition from the inpatient programme. If goals are identified they may be readmitted to St Joseph for follow up rehabilitation such as management of personal care or gait training for a short allocated period.

Programme Setting:

This occurs in the structured therapy setting, off site sports stadium, home environments / assessments, therapeutic arts events in the centre, therapeutic visits out of the centre and overnight leave.

Services offered in the Spinal Cord System of Care

The following services are provided to all individuals in the Spinal Cord System of Care:

- Spinal Cord Injury Consultant
- Rehabilitation Nurse
- Occupational Therapy
- Recreational and leisure activities – sports / arts
- Physiotherapy, including aquatic therapy and adaptive sports programmes
- Clinical Psychology
- Case Management and transition planning
- Patient liaison and advocacy
- Patient Education Programme
- Pharmacist
- Play Specialist (young people)
- School Teaching Service (young people)
- Posture and Seating assessment

Depending on the unique needs of each individual, the following services are also provided:

- Nutrition Services
- Speech Language Therapist – communication assistance
- Psychosexual therapy
- Chaplaincy
- Family Counselling
- Vocational services
- Orthotics
- Other medical or surgical consultations
- Adaptive technology service etc.
- Interpreting service
- Liaison Psychiatry
- Liaison with wheelchair services

Follow up visit:

Appointments after discharge from the ward are arranged for a Spinal Outpatients visit to clinic if needed and the outreach team can visit at home if required.

Diagnostic and screening services:

Provision is available for medical care for most medical/paediatric conditions with the exception of paediatric Intensive Care. All medical issues that may be a factor for a person with spinal cord dysfunction can be managed with consultation from various other specialists, as requested by the spinal doctors and team.

In addition, diagnostic imaging, laboratory services and pharmacy services are available within the trust.

The NSIC provides specialist care for those with spinal cord injury and associated complications such as

- Autonomic dysreflexia
- Bowel function
- Bladder function
- Circulation
- Cardiac Function
- Cognition / Psychological difficulties – Mood disturbance, pre morbid mental health problems, adjustment issues, ABI, special needs, pain management.
- Dysphagia
- Fertility
- Infectious disorders
- Medication
- Metabolic Function
- Musculoskeletal complications
- Neurological changes
- Nutrition
- Pain – acute and persistent pain
- Respiration
- Sexual function
- Skin integrity
- Spasticity

Addressing Participation and Functioning:

The NSIC is capable of addressing functional and goal directed services. An established Goal Planning Process is the structure for patient centred regular goal planning. An interdisciplinary core team includes Doctors, Nurses, Occupational Therapists, Physiotherapists and Clinical Psychologists. The centre's programme is structured around the ICF terminology of Impairment Activity and Participation.

All staff work with the patient and family to address aspects related to an individual capability to function using the goal planning process within their intended living environment.

Examples include:

- Activities of daily living
- Assistive technology
- Community integration
- Drivers potential assessment
- Durable Medical Equipment
- Emergency Preparedness
- Environmental Modifications
- Leisure and recreation
- Medication
- Mobility
- Orthosis/Prosthetics
- Personal care assistant training
- Seating
- Vocational Services
- Educational needs

Activity Limitations:

Individuals in this programme will have difficulty executing activities that may include any of the following:

- Activities of Daily Living
- Self-Care
- Mobility
- Communication

Discharge support:

All patients and their families are allocated a Case Manager upon admission to the programme who will assist with identifying potential difficulties with discharge transition and support people in their decision process prior to moving on from the rehabilitation environment. Discharge conversations are initiated within 2 weeks of admission; the Trust policies for the discharge process are followed.

A Clinical Psychologist is available to work with adults, children and their families. There is a Family Counsellor and a Patient Support Officer, who is tetraplegic who can meet with both child and family. There are sibling workshops which are run to assist the children within a family find out more about SCI.

Chaplaincy services are also available, based on spiritual needs.

Peer support is available through our staff and partner charities which offer support and encouragement as well as practical suggestions regarding moving on with life.

Discharge from the programme takes place when the mutually agreed goals have been achieved and the service seeks as a guideline to have length of stay as outlined by the previous South of England Standards, although this is flexible and any untoward factors will be considered to extend or shorten this. The Trust does operate a “Choice Directive” policy to ensure people have safe options for discharge who need to transition from the service. The team endeavour to discharge to a suitable venue of their choice but sometimes interim options must be considered and carried through if safe and delivering appropriate care.

Transition / discharge criteria

A mutually agreed discharge date will be set when one or more of the following are met:

A patient has achieved all the goals set; it is felt a patient will not gain any further rehabilitation goals; a patient is no longer engaging in the Programme or a patient’s behaviour is such that they need to leave the programme.

Cultural Diversity:

Individuals of all cultures are admitted and the programme strives to meet individual cultural needs of all patients. An example of how we strive to meet cultural diversity is through our

chaplaincy and multi faith room that has been established to be useable for various religious and cultural purposes.

Non-discrimination Policy:

The NSIC Rehabilitation programmes do not discriminate in their activities or programmes, or in admission. The Equality Act 2010 extends protection to the 9 protected characteristic groups; race, gender, disability, age, maternity and pregnancy, religion or belief, gender identity, marriage and civil partnerships and sexual orientation. Our goal is to embrace the diversity and unique experiences of our community.

Education and Training:

A comprehensive, individualised patient and family education programme is initiated upon admission and modified as the individual progresses in his/her rehabilitation programme. An established goal planning process takes place throughout a patient's stay and the patient can invite his or her relatives or friends.

All members of the patient's rehabilitation team provide education in prevention of additional problems related to risks of complications which can occur as a result of living with a spinal cord dysfunction. An individualised education manual is provided to the patient and family.

The education programme covers all areas following spinal cord dysfunction and includes elements related to primary prevention of additional trauma or injury to the spinal cord. If patients require a one to one approach due to cognition poor concentration, this can be provided.

Training and education will also help to overcome barriers that limit one's ability to participate in social, leisure and vocational aspects of life activities, including safety in these environments.

Content can also be related to previous health complications that may further complicate spinal cord dysfunction and training for people who will be providing care when individual returns the community or moves on to a different level of care in the rehabilitation continuum can be provided. A new online education resource was launched this year, enabling patients to have an ongoing resource for learning once they are discharged.

There is a comprehensive day for relatives and friends to learn more about SCI and meet people in similar situations to their own.

There are numerous opportunities for staff training at all levels of expertise from core requirements to a Masters Programme in Advanced Management of Spinal Cord Injury.

Supervision of undergraduate students in nursing, occupational therapy and physiotherapy are supported on placement.

Research activity:

There is strong research activity within the NSIC and associated links to other organisations. There are staff members with professional, academic and clinical roles. These posts facilitate trainees and doctorial research students to the centre. There are also national and international links and there are a number of university collaborative agreements. There are internationally recognised researchers within the NSIC staff. The Stoke Mandeville Spinal Foundation (SMSF) is also developing into a key research arm in the future. A Director was appointed in November 2011. A number of staff have a special interest in research groups and individual staff are Trustees of an SCI charity.

Lifelong Care:

Based on individual needs, the Spinal Cord Injury Consultant and the Interdisciplinary Team, works with the patient over the course of his/her life, in meeting the challenges of living with impairments and activity limitations. This team will assist individuals served with lifelong health issues, self management and prevention of potential risks and complications. There are busy clinics for each consultant, Monday to Friday with the support of an interdisciplinary team. The spinal outpatients department is starting to use telehealth technology for some of the consultations.

System Relationships:

The NSIC Spinal Cord System of Care has established relationships with other providers in the broader rehabilitation continuum to help meet the unique and changing needs of individuals in the programme. These relationships are varied, diverse and changing.

Team members serve as resource to other providers for education and training to ensure personnel competency in addressing the needs of the individual along the continuum of care.

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