



Overview

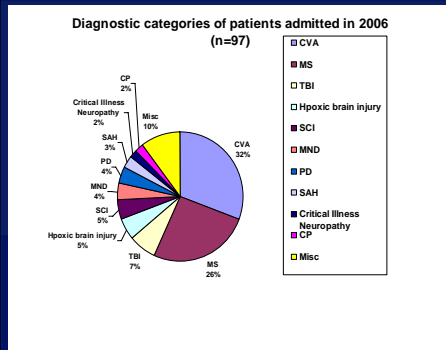
The Alderbourne Rehabilitation Unit (ARU) is a District General Hospital (DGH) based unit providing specialist rehabilitation services since 1990. While it was originally a purpose built YDU, it is now a 20 bed unit for post-acute inpatient rehabilitation and planned short stay admissions. ARU also has out patient services such as multidisciplinary clinics, RM clinics and Specialist clinics like spasticity and nurse led clinics.

Location of Service: Hillingdon Hospital, Uxbridge. ARU's location within a district general hospital with ready access to acute medical/surgical and investigative facilities enables early transfer of patients to the unit for their rehab.

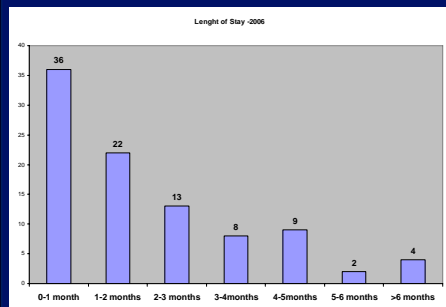
Resources: ARU is a purpose built unit located on the ground floor with a quadrangle garden and consists of 12 single rooms and 2 four bed bays. OP clinics are held within the Unit maximising staff utilisation/efficiency and continuity of care. An interdisciplinary team of 25 nursing staff, 5 physiotherapists (4 for inpatients and 1 for outpatients), 3 occupational therapists, 3 therapy assistants, 1 speech and language therapist, 0.6 WTE clinical psychologists. There is appropriate input from the hospital dietetics and pharmacy departments. There are 2 part time RM consultants who also work in other regional units thus facilitating communication and alliances within the region.

Outcome measures: UK FIM/FAM is recorded on admission and discharge. Contact : Prof R.S Hanspal. Phone 01895 279739

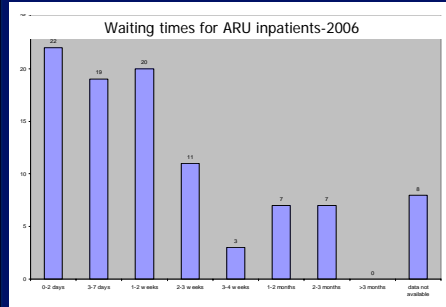
Clientele served: Adults with complex disability primarily due to stroke, MS, brain injury, and other long term conditions. The unit admits patients from the London Borough of Hillingdon and adjoining areas.



Inpatient admission data 2006: The ARU has admitted an average of 100 inpatients per year for the past 6 years. In 2006 CVA (32%), MS (26%), brain injury(13%) were the common conditions admitted. The mean length of stay in 2006 was 65.9 days (median 49). Hillingdon Hospital inpatients who needed inpatient rehab were transferred to ARU within a mean of 7.2 days



Multiple Sclerosis services at ARU The unit has shared protocols of care for people with MS providing Integrated MS services with direct access to all relevant specialists. This service is co-ordinated by an MS specialist nurse based within the Unit. The Neurologist with a special interest in MS is also attached to the Rehabilitation Unit working closely with the Rehabilitation physicians and the specialist rehabilitation team with shared care facilities. Patients with MS who may need initiation, alteration or cessation of disease modifying agents are identified and promptly seen by the neurologist who is also based on the ARU.



Multiple Sclerosis and rehab nurse specialist role The nurse specialist role centres around promotion of patient's self management by developing and participating in educational programs on MS in conjunction with the MD team (local and national) MS charities. The MS specialist nurse is pivotal in providing a greater understanding of the condition, and adopting a holistic, collaborative and coordinated approach. (UKMSSNA's 'Key Elements for MS specialist nurses')¹. The multiple sclerosis specialist nurse assumes an additional role as a urology specialist nurse providing targeted care towards MS patients needs. In addition, she co-ordinates shared protocols of care with the **urology** department facilitating good communication and improving the efficiency of referral process. As recommended by the NICE guidelines² patients with MS can self refer themselves to the nurse specialist



Motor Neuron disease: care is co-ordinated by a team of neurologist, rehabilitation medicine specialist, palliative care team, dietician, community physiotherapists and occupational therapists. Short inpatient admissions may be arranged for intensive multidisciplinary rehabilitation. Regular meetings are held on the unit with representatives of the MND Association and the team of professionals. The ready access to the EC on the ARU is an asset for MND patients and their carers.

Minimal Awareness and Persistent Vegetative State : Patients who are in a minimally conscious state or persistent vegetative state are assessed and accepted for admission at an early stage often directly after discharge from the intensive care unit. The team has considerable experience in clinical management and care of patients in low awareness states. Their care is continued after discharge to the community. The continuity of care from early post acute phase to placement in the community ensures a seamless service.

- Benefits of a DGH based district rehab Unit**
- Provides early transfer to post acute rehab
 - Unblocks acute medical beds for DGH
 - Specialist Rehab closer to home for patients
 - Ready access to acute facilities round the clock
 - Better re-integration into community
 - Patients can easily access outpatient services post discharge
 - Complements existing regional services

Spasticity Clinic: The ARU operates a weekly multidisciplinary spasticity clinic. Referrals can be made through the 'choose and book' system. Botulinum toxin injections followed by physiotherapy, occupational therapy as well as splinting is provided as part of a comprehensive package of clinical management care. The service is also extended to other patients in the hospital e.g. in Stroke Unit.

Outpatient Neuro-physiotherapy and Occupational Therapy: General Practitioners, consultants and other health professionals are able to refer patients for assessment by a specialist neuro PT/OT. Splinting and casting orthotics can be accessed where needed.

North Thames Regional Environmental Control and Equipment Services (NTRECES): This regional service that serves a population of 7.2 million over 27 PCT's is also based on the ARU

ARU & NSF for long term conditions³ In accordance with the national service framework for long term conditions QR11, the ARU team also ensures that when patients with long term conditions are admitted to hospital with medical/surgical issues their rehabilitation and self care needs are also addressed. The unit also ensures that all other QR's are appropriately addressed.

References:

1. MS Trust, UKMSSNA, RCN. Specialist nursing in MS - the way forward. The Key elements for developing MS specialist nurse services in the UK. MS Trust; Letchworth:2001
2. MS National Clinical guideline for the diagnosis and management in primary and secondary care. The National Collaborating centre for chronic conditions, 2004.
3. NSF for long term conditions- Dept of Health,2005 <http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/index.htm>