



Consultant led rehabilitation outreach service to large nursing home in Castleford, West Yorkshire
A review of clinical practice between June 2005 and June 2006
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Components of team:

- Consultant in rehabilitation medicine
- Physiotherapist employed by the nursing home
- Nursing staff
- Community rehabilitation team

Client served:

Young adults with severe and complex neurological disabilities

Standards

- Quality Requirement number 5 of the NSF for long term conditions - ongoing access to rehabilitation.
- BSRM Standards 1.2-1.5 (access to rehabilitation), 6.4-6.6 (coordination), 8 (follow up) and 10.2 (liaison).

Introduction:

- There is unmet need for health care in clients in nursing home and Rehabilitation Can Help
- Morbidity, disability, and type of care home are significantly associated with utilisation of general practitioners
S Kavanagh, M Knapp, BMJ 1998
- 92 people with ABI resident in Glasgow - access to physical disability community team (28/92 cases) or other community teams (5/92).
- Proactive medical review was uncommon.
- Medication review in (21/92) only.
McMillan TM, Laurie M, Young, Clin. Rehab. 2004
- Longer term rehabilitation works and can lead to discharge in to community settings.
D. Shaun, Gray and Robert S. Burnham, Arch of Phys Med and Rehab 2000

Intervention

Consultant led outreach clinic to nursing home with ad hoc support from community rehabilitation team and support from nursing home staff.

Setting

Wheldon View: 29 beds "YDU" and 47 beds for over 65.
Fairburn mews: 10 beds Huntington's and 10 TBI with behavioural difficulties
Fairburn vale 20 beds for complex neurodisability
1 FTE Senior Physiotherapist is based Fairburn vale

Poster's Message

The contribution of rehabilitation medicine specialist to people with long term neurological conditions living in nursing homes is important part of their continuing care in the community

Methods:

Retrospective study of clinic letters of 12 months period between June 2005 and June 2006. The letters were retrieved from the Consultant's secretary computer. Excel was used for further analysis.

Results:

- 14 clinics were held in 12 months
- 37 patients
- 66 attendances.
- Fairburn Mews 17 episodes of care
- Wheldon View 43 episodes of care
- Fairburn Vale 7 episodes of care
- Number of episodes of advice on adding or change medication was 25
- Number of Botulinum toxin therapy was 16

Referrals for further medical services

Number of Clients referred was 23.
Examples of referrals*

- Community rehabilitation team 3
- Admission for Rehabilitation 2
- Referral to Neurobehavioural Unit 1
- Physiotherapy/ gait training 2
- Further inpatient rehabilitation 2
- Speech therapy including swallowing 3
- Orthotic /prosthetics/ upper limb splints 4
- Percutaneous gastrostomy 2
- Medical appointment 6
- Intrathecal baclofen therapy 2
- Environmental control system 1
- Referral for social services 1
- Ct scan 1
- *Some patients had more than one referral

Case Study

35 year old gentleman with Nasopharyngeal Carcinoma, brain injury following a fall. Treated in Regional Rehabilitation Centre and discharged with mobility and behaviour goals. Needed medication review for psychological state, and spasticity management. Discharged to Neurobehavioural Unit with view to community living long term.

Table 1: Frequencies of same client review in 1 year

	Fairburn Mews	Wheldon View	Fairburn Vale	Total Clients
Seen X1	8	2	3	13
Seen X2	3	10	2	15
Seen X3	1	4	0	5
Seen X4	0	1	0	1
Seen X5	0	1	0	1

Table 2: no. of residents, no. required hospital admission (any cause), discharges from NH or death

	Fairburn Mews	Fairburn Vale	Wheldon View
No. of Residents	11	22	N/A
Hospital admissions	4	7	N/A
Discharges	1	5	N/A
Deaths	0	3	N/A

Completing the cycle :

Developments as a result of this work

- Closer working with a recently appointed GPWSI (although problems with cost of medication to one practice).
- Feedback to funders with written rehabilitation assessments.
- New referrals to consultant as part of NH assessment.

Proposed

- Improving routine data collection at homes, looking at rates of discharge to community.
- Further discussion on formal measures of outcome.

Discussion:

- People in nursing homes have unmet health care needs - Close liaison with secondary care is beneficial
- In each home Therapists/ Senior Nurse have crucial role in identifying suitable clients, book appointments, collect notes, arrange time for visit, and liaise with GP implementing recommendations.
- Barriers to care include lack of training and frequent turnover of NH carers some homes worry about implementing care against the patients wishes, and fear care standards.
- Relatives greatly appreciate presence of medical overview, can share information and reduce pressure on homes.

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