NHS
Southport and Ormskirk Hospital
NHS Trust

PATIENT INFORMATION

Your Journey from Admission to Discharge

North West Regional Spinal Injuries Centre, Southport

INTRODUCTION

This leaflet aims to explain what you can expect from admission to discharge.

The North West Regional Spinal Injuries Centre (NWRSIC) is based at Southport.

THE RIGHT PLACE FOR YOUR CARE

- The NWRSIC is one of 12 specialist spinal cord injury (SCI) rehabilitation centres in the UK and Ireland and is part of Southport and Ormskirk NHS Hospital Trust.
- We are commissioned to provide spinal cord injuries services to the population of the North West, which consists of approximately 7 million people in Cumbria, Lancashire, Manchester, Cheshire, Merseyside, and the Isle of Man.
- The NWRSIC is an internationally recognised Centre of excellence that has the largest ventilator-dependent and

weaning programmes in Europe for the treatment of people who will require permanent ventilation following SCI.

- The NWRSIC has 43 in-patient beds (acute and rehab beds) and 8 community beds, managed by our Spinal Outreach Team.
- Once the Multi-disciplinary Team (MDT) confirms your rehabilitation goals are complete, we will work with your local authority to discharge you back to your own area.

"As far as the North-West is concerned, this is the only hospital to be at." Glynn, a previous patient at NWRSIC.

SOUTHPORT AND THE SURROUNDING AREA

- Southport is a seaside town in Merseyside.
- The Centre is a couple of miles from Southport town centre but is easily reached by car, bus or taxi. There are train and bus stations in Southport town centre.
- There is a small retail park, large supermarket and some restaurants close by to the Spinal Injuries Centre.
- The duck pond on site is popular with our visitors.

- We have a day room where you can relax with friends and family

- For further information, see the NWRSIC on http://www.southportandormskirk.nhs.uk/spinal/

MISSION STATEMENT AND CARE PHILOSOPHY

Care in the Centre is undertaken by skilled professionals who make sound judgements based on wide experience, research and specific expertise in advanced technologies. Care consists of a partnership between you, your family, carers and staff at the Centre. We assess, plan and implement care to meet individual needs and to prepare you for living as independent a life as possible following discharge.

Our mission is “to provide every opportunity for individuals to achieve their maximum potential in order to adopt the lifestyle of their choice within the extent of their ability.” Initial rehabilitation treatment focuses on working with you physically and psychologically, so that in a short period of time you can:

- Maximise your neurological recovery and general health.
- Learn about all aspects of your injury and care, through formal and informal educational sessions.
- Functionally be enabled to return home as independent and productive as possible.

DISCHARGE PLANNING

In order to ensure a timely and safe discharge, Case Managers will commence discharge planning with you from admission.

Case Management Team: Andrew, Tara, Sheila, Alison and Jane

- Following admission, you will undergo an assessment period (approx. 2weeks) so that a more accurate estimated discharge date can be agreed.
- We will aim to make your rehabilitation as seamless as possible and your estimated discharge date (EDD), will be documented in your patient passport (a document to record your progress). Your EDD may change as it is dependent on your clinical condition and progress of individual rehabilitation goals, which will be reviewed regularly.

- Should you feel that rehabilitation at Southport is not for you, or you do not engage in the process, then we will support you in expediting your discharge.
- The Trust has a 'No Smoking' Policy.

EXPECTATIONS OF REHABILITATION

- On admission, after assessments, you will discuss and agree realistic goals with your treating team (short-term and long-term goals).
- Individual SMART (Specific, Measurable, Attainable, Realistic and Timely) goals are reviewed regularly and discussed at goal-planning meetings, re-confirming your EDD.
- You will need suitable clothing and footwear to engage in rehabilitation; please liaise with the Nursing or Therapy team for further information.
- We acknowledge that this is a lifelong condition, so provide the opportunity to support and educate you and your family on your care needs. We would encourage you to take an active part in our ward based patient-education sessions, to enable you to know your injury and live as independently as possible after discharge.
- No person or spinal cord injury is the same. The MDT will work to enable you to be as independent as possible within your current ability. They are unable to influence any neurological recovery, for that, nature has to take its course. Any delay in coming to Southport should not compromise any neurological recovery you may have.
- You may be identified to continue your rehabilitation in an outreach bed with our Spinal Outreach Team; this is an MDT clinical decision as to where goals are best met to facilitate your transition into the community.

- We have a supply of wheelchairs for patient use whilst at Southport. It is NOT the Centre's responsibility to provide a wheelchair to facilitate discharge. If necessary, a referral will be made to the Wheelchair Services in your own area; they will be responsible for assessing your need and the provision of equipment. We will advocate for you and pursue where possible but are reliant on the services in your area to support you.

YOUR EXPERT TEAM

- An MDT, including Consultants/Doctors, Matron, Nurses, Case Managers, Occupational Therapists, Physiotherapists and our Psychology Service, will begin to plan your discharge from the Centre as soon as you are admitted. You will be allocated a key worker from each discipline.
- The team will work closely with you and your family to ensure your rehabilitation meets your individualised care needs and goals, to facilitate a safe and timely discharge.

PLANNING YOUR DISCHARGE

- You will be transferred from the Centre when your treating team confirms that your goals are complete and you are medically optimised, as you will no longer require a hospital bed within a specialist commissioned service.
- Dependent on your care needs at time of discharge, you may require support to enable you to live as independently as possible. Case Management will plan your discharge with you and provide the appropriate information regarding services, funding and care in your area.
- A member of the therapy team may visit your home to assess the enviornment and suitablity for short and long-term needs. If you are able to manage your care needs independently and home is deemed accessible, the MDT may discuss the option of trialing day or weekend leave, as a means to address any barriers you might encounter prior to your discharge. ALL leave is subject to medical authorisation.
- If your home is not suitable and temporary downstairs living cannot be accessed, an interim placement may be required. Your choice of care and support is the focus of the assessment and decision making process. (Social Services may complete a financial assessment and they may request you fund or contribute towards the cost of care).
- If you think your home may not be accessible, we would advise you to apply for re-housing via your local council, as soon as possible. Despite the application process being lengthy, apply anyway; you are not committing to move. We can provide supporting evidence if required

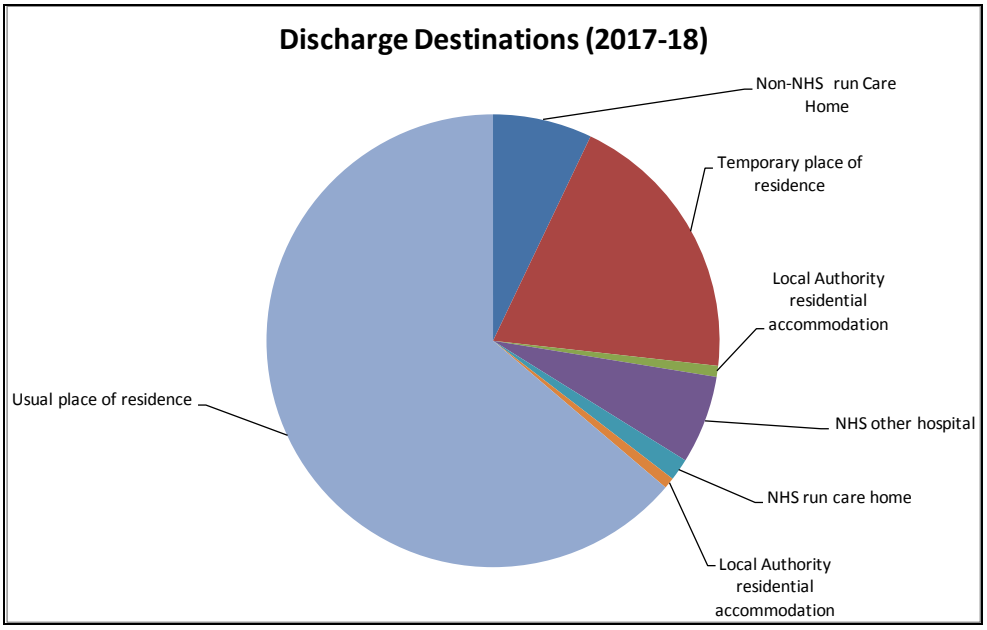
and guide you with the bidding process once you are admitted.

- Your safe and timely transfer from the Centre will also allow new patients who need acute hospital treatment to be admitted without delay and will assist with the throughput of patients within the NWRSIC.

DESTINATION FOR YOUR DISCHARGE

It is very improtant to consider all options for discharge, as some processes can be lengthy and are, unfortunately, not a reason to stay in hopsital. We would encourage you and your family to discuss this with your MDT to avoid delays and ensure you have a safe place to go to when you have completed your goals. Case Managers will support you with re-housing applications, if required.

This pie chart illustrates discharge destinations in the period between January 2017 and September 2018. As you can see not everyone was able to immediately return home. The sooner we work together to formulate discharge destination plans, considering; temporary downstairs living, adaptations or re-housing, the better for you and your family.



OUR COMMITMENT TO YOU

- Patients should receive the **Right treatment**, in the **Right place** and by the **Right professional.**
- Case Managers will arrange regular goal planning meetings to review goals and encourage communications between the MDT, you and your family and carers.
- We place a high priority on keeping your stay at NWRSIC to a minimum. This will be beneficial to your psychological wellbeing, allowing you get back to your support network and reduce the risk of hospital acquired infection.
- When the MDT confirms your immediate goals are complete and you are medically optimised and no longer require a hospital bed, the MDT will discharge you back to your own area. Therapists can refer you to community services, if there are ongoing therapy goals to continue.

YOUR COMMITMENT TO US

- Adhere to the 'partnership' agreement.
- Attend ALL rehabilitation and patient education sessions, as able.
- Take responsibility for your discharge destination and the consideration of alternative housing arrangements or adaptations should your current property be un-suitable to facilitate a safe discharge. Case Managers can support you with this.
- Be respectful to staff, other patients and visitors, as per the Trust policy.
- Notify ward staff if you are leaving the Centre's grounds for purposes other than therapy (for your safety).

SUMMARY

The NWRSIC and Southport and Ormskirk Hospital NHS Trust understands that patients and families, when leaving hospital, sometimes need time to make choices which can be life-changing, this can be stressful for you and your family.
Our hospital works in partnership with community services and Local Council Authority to provide services which give you the time to help you make these choices in a more suitable environment.

*You **cannot** choose to remain in a hospital bed when you no longer need this level of care and therefore will be transferred from hospital when your treating team assesses that you are fit for transfer.*

Your safe and timely transfer will allow new patients, like yourself, from local trauma centres, who need acute hospital treatment to be admitted without avoidable delay.

We pride ourselves in delivering quality care and rehabilitation in a patient-centred approach, focusing on individual needs. We support all our patients (new and old) to lead as independent a life as possible, through liaison with local hospitals, Clinical Commissioning Groups, General Practitioners, Local Councils and care commissioners.

FOR MORE INFORMATION PLEASE CONTACT US AT:

North West Regional Spinal Injuries Centre
Southport & Ormskirk Hospital NHS Trust
Southport & Formby District General Hospital
Town Lane
Southport
PR8 6PN
Tel: (01704) 704333
http://www.southportandormskirk.nhs.uk/spinal/

If the NHS agree that the local authority have offered a package of care that is suitable and sought to reflect the patient's choice, if the patient continues to unreasonably refuse the care package offered by the local authority, they cannot stay in a hospital bed indefinitely and will need to make their own arrangements so that they can be discharged safely (Care Act 2014).

Southport & Ormskirk NHS Trust

During your contact with us, it is important that you are happy with your care and treatment. Please speak to a member of staff and/or the ward/department Sister/Charge Nurse if you have questions or concerns.

MATRON

A Matron is also available during the hours of 9am to 5pm Monday to Friday. During these periods, ward/department staff can contact Matron to arrange to meet with you. Out of hours, a Senior Nurse can be contacted via the ward/department to deal with any concerns you may have.

INFECTION CONTROL REQUEST

Preventing infections is a crucial part of our patients' care. To ensure that our standards remain high our staff have regular infection prevention and control training and their practice is monitored in the workplace. We ask patients and visitors to assist us in preventing infections by cleaning their hands at regular intervals and informing staff of areas within the hospital that appear soiled.

As a patient there may be times that you are unsure whether a staff member has cleaned their hands; if in doubt please ask the staff member and they will be only too happy to put your mind at ease by cleaning their hands so that you can see them.

SPECIAL INSTRUCTIONS

ANY CONDITION SPECIFIC DANGER SIGNALS TO LOOK OUT FOR:

CONTACT INFORMATION IF YOU ARE WORRIED ABOUT YOUR CONDITION

- Your own GP

OTHER USEFUL TELEPHONE NUMBERS/CONTACTS:

NHS 111
Stop Smoking Helpline (Sefton) – 0300 100 1000
Stop Smoking Helpline (West Lancashire) – 0800 328 6297

Please call 01704 704714 if you need this leaflet in an alternative format

Southport and Ormskirk Hospital NHS Trust

Ormskirk & District General Hospital
Wigan Road, Ormskirk, L39 2AZ
Tel: (01695) 577111

Southport & Formby District General Hospital
Town Lane, Kew, Southport, PR8 6PN
Tel: (01704) 547471

FOR APPOINTMENTS

Telephone (01695) 656680
Email soh-tr.appointments@nhs.net

Please remember to complete the **attached** *Friends and Family Test*.
Alternatively, you can complete the *Friends and Family Test* on-line by going to: southportandormskirk.nhs.uk/FFT
Thank you

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