Queensland Spinal Cord Injuries Service Model of Care

Princess Alexandra Hospital

Metro South Health

Queensland Government

Table of Contents

Commonly Used Abbreviations

ABIOS	Acquired Brain Injury Outreach Services
ADL	Activity of Daily Living
ASIA	American Spinal Injuries Association
CNC	Clinical Nurse Consultant
COPM	Canadian Occupational Performance Measure
DOH	Department of Housing
DOR	Division of Rehabilitation
FIM	Functional Independence Measure
GPM	Goal Planning Meeting
GP	General Practitioner
IRM	Introduction to Rehabilitation Meeting
IVP	Intravenous Pyelogram
NDIS	National Disability Insurance Scheme
NIISQ	National Injury Insurance Scheme Queensland
NUM	Nurse Unit Manager
OPD	Outpatients Department
PCRM	Patient Centred Rehabilitation Meeting
QSCIS	Queensland Spinal Cord Injuries Service
SCI	Spinal Cord Injury
SCIR	Spinal Cord Injury Response
SIU	Spinal Injuries Unit
SMART	Skin Management and Rehabilitation Team
SPOT	Spinal Outreach Team
TRP	Transitional Rehabilitation Program
WHO	World Health Organisation

Glossary of Terms

ASIA Scale	The American Spinal Injury Association (ASIA) Standard Neurological Classification of Spinal Cord Injury is a standard method of assessing the neurological status of a person who has sustained a spinal cord injury.
Carers	Carers can include family members, friends or neighbours who have been identified as providing regular and sustained care and assistance to the client/patient without payment other than a pension or benefit. Carers frequently live with the person for whom they are caring.
Core Team	For the purposes of this document the core team refers to the patient's primary treating team including spinal consultant, registrar, physiotherapist, psychologist, occupational therapist, social worker and nursing team.
ICF	The International Classification of Functioning, Disability and Health, (ICF) is a classification of health and health-related domains. These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. Since an individual's functioning and disability occurs in a context, the ICF also includes a list of environmental factors. In clinical settings ICF is used for functional status assessment, goal setting & treatment planning and monitoring, as well as outcome measurement.
Functional Independence Measure (FIM)	The Functional Independence Measure (FIM) scale assesses physical and cognitive disability. This scale focuses on the burden of care – that is, the level of disability indicating the burden of caring for them. .
Interdisciplinary	Interdisciplinary involves the combining of two or more academic disciplines into one activity. It is about creating something new by crossing boundaries, and thinking across them.
Model of Care	A "model of care" broadly defines the way health services are delivered. It outlines best practice care and services for a person or population group as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place. The model describes: • types of activities to be delivered to patients by a provider, health professional, or care team • types of services to be provided by an organisation • the appropriate stage for an activity or service to be delivered • the location or context where the activity or service will be provided • the health care team and community partners that will provide the service • the policy framework for the model of care
Patient/Client	For the purposes of this report the use of the term patient/client is interchangeable. The term patient is most often used to refer to individuals within the hospital setting and the term client is used to refer to individuals in the community setting

1. Executive Summary

The Queensland Spinal Cord Injuries Service (QSCIS) is a state-wide service that has been established to assist individuals with spinal cord injury in achieving their maximum physical, social and psychological rehabilitation potential across their lifespan and across the continuum of care.

In 2011 a best practice model of service delivery was developed within QSCIS with the purpose of providing an overarching design and framework for the provision of an innovative and holistic rehabilitation service that is informed by rehabilitation philosophy, theory, evidence and best practice. The development of a new model of care was a core objective of a three year quality improvement project – The Spinal Advancement Project. The model was developed in consultation with staff, patients and external consultants at all stages of its development. The key drivers for change of the existing model were the External Review of the Princess Alexandra Hospital Spinal Injuries Unit (May 2008), the 2007 Allied Health Review and the Best Practice Survey results in more recent years.

This model of service delivery has emerged to meet the challenges of providing health care to our growing spinal cord injury population and consistently achieving the QSCIS mission. It is informed by evidence that earliest access to specialist acute care and rehabilitation services improves outcomes for individuals with spinal cord injury. (WHO 2017, ACT RHI 2018)

Developing a model of care has allowed staff to think through what happens, when and why and has assisted in streamlining processes and workflow. It aims to ensure people get the right care, at the right time, by the right team and in the right place. The QSCIS model of care provides a plan for healthcare for individuals with spinal cord injury. It describes the aims and principles of service delivery, the evidence based practices and frameworks used at QSCIS and the flow of patient services as they progress through the continuum of care.

The purpose of this document is to:

- Describe the current model of service delivery within QSCIS
- Define the types of service offered to patients and stakeholders of QSCIS services
- Articulate the governance structure in operation within QSCIS
- Identify the goals and outcomes of clinical services provided within QSCIS

2. Introduction to the Queensland Spinal Cord Injuries Service

The Queensland Spinal Cord Injury Service (QSCIS) is a state-wide service that operates under the Division of Rehabilitation (DOR), Princess Alexandra Hospital within the Metro South Health Service. The DOR's vision is to 'Empower People With Disability To Participate In Life' through their mission – 'Delivering Innovative Person-Centred Rehabilitation That Enhances Quality Of Life For People With Disability'.

The services offered by the QSCIS are informed by evidence that earliest access to specialist acute care and rehabilitation services improves outcomes for individuals with spinal cord injury. (WHO 2017, ACT RHI 2018)

In recognition of the need to offer specialised clinical health services to individuals with spinal cord injury across the continuum of care, the QSCIS offers three phases of intervention:

1. The **Spinal Injuries Unit** (SIU): provides acute management and primary rehabilitation services to individuals with spinal cord injury.
2. The **Transitional Rehabilitation Program** (TRP): provides community-based rehabilitation and support in the transition from hospital rehabilitation to community living, for individuals discharged from the Spinal Injuries Unit.
3. The **Spinal Outreach Team** (SPOT): provides a specialist outreach service for people with spinal cord injuries, their families and the services that support them.

The three QSCIS services work in close collaboration under a unified rehabilitation framework which emphasises the importance of providing effective, evidence-based and patient-centred clinical services to individuals with spinal cord injury in Queensland. The model of care outlined in this document describes comprehensive interdisciplinary spinal cord injury rehabilitation across the three phases of care.

At QSCIS our mission is to assist individuals with spinal cord injury to achieve their maximum physical, social and psychological rehabilitation potential across their lifespan and the continuum of care.

Figure 1: QSCIS Continuum of Care

2.1 QSCIS Objectives

The core objectives of QSCIS in line with the DOR strategic plan are to:

- purposefully engage consumers in planning, developing, implementing and evaluating rehabilitation services
- actively develop a positive culture that attracts and sustains our interdisciplinary rehabilitation workforce
- continuously build a culture of influential, innovative leadership in rehabilitation
- consistently translate flexible thinking and continuous improvement into daily work practice
- responsibly manage and monitor resources within collaboration and transparency
- actively identify, create and maintain partnerships for the future
- provide excellence in clinical care to individuals with spinal cord injury through a coordinated approach across the continuum of specialist acute and rehabilitation services
- provide a central state-wide referral service for all individuals living with spinal cord injury in Queensland and Northern NSW who meet the general criteria for admission to the spinal injuries unit
- provide state-wide leadership in the development of services for people with spinal cord impairment through participation in activities such as strategic planning and policy development, health promotion, consultation, innovation and advocacy
- provide networking and consultation with other hospitals and care providers in the management of individuals with spinal cord injury
- provide clinical leadership and expertise in the management of spinal cord injury
- promote evidence based practice, quality and safety in all aspects of service delivery and management.
- encourage ongoing world class collaborative research to improve quality of life for people with spinal cord injuries.

3. The QSCIS Model of Care

The model of care is a framework that establishes how spinal cord injuries services at QSCIS are delivered. It has been developed in collaboration with a broad range of stakeholders and outlines in detail all aspects of service delivery. The new model aims to provide equitable, consistent, and a systematic approach to rehabilitation for people with spinal cord injury. The model provides increased flexibility in rehabilitation programs that are tailored to an individual's specific needs. It brings together evidence based principles to create a comprehensive service for patients.

The QSCIS model of care is derived from the World Health Organisation International Classification of Functioning, Disability and Health (ICF; WHO, 2001). One of the core principles of the ICF is that disability is a universally human experience. Every human being can experience a decrement in their health at some stage in their life, and therefore experience some form of

disability. The ICF shifts the focus from ”cause of injury’ to ‘impact of injury’ and emphasises that the purpose of rehabilitation is to facilitate the individual in achieving their maximum level of ‘health’ focussing on their different abilities rather than ‘disability’.

The QSCIS model of care uses an interdisciplinary team approach where there is collaboration; team assessments and goal planning; and patients and relatives are team members. At QSCIS the patient is considered to be the primary focus of all clinical activities performed within the interdisciplinary team. It is the role of the treating team to assist and facilitate the patient towards achieving their personal goals. These goals are holistically focussed, individually tailored and generally fall within the five core areas of physical functioning, activity levels, social participation, environmental access and interpersonal factors.

This new rehabilitation model of care aims to improve patient outcomes, service delivery efficiencies and collaboration with and between health professionals.

3.1 Key Features of the QSCIS Model of Care

The key features of the QSCIS model of care are:

- early access to specialist acute and rehabilitation services, transitional rehabilitation and lifelong follow-up to optimise outcomes
- provision of patient-centred, goal directed and culturally sensitive clinical services which aim to optimise consumer participation in valued life roles across the continuum of care
- recognition that rehabilitation for individuals with spinal cord injury requires specialist expertise in the management of autonomic dysfunction, cardiorespiratory and metabolic compromise, bladder, bowel and sexual impairment, and impaired sensation.
- recognition that disability and functioning is a dynamic interaction between an individual’s health condition as well as their environment and personal factors
- emphasis on the importance of effective interdisciplinary teamwork, communication and accountability
- emphasis on the importance of attracting and maintaining skilled and experienced staff who can work autonomously and who are provided with the support they require to work effectively and safely
- emphasis on the utilisation of evidence-based reflective practice models with the purpose of maintaining a continually high quality of service delivery
- maintenance of effective and efficient clinical and administrative policies and procedures
- clear and concise documentation that uses easy to understand patient language, devoid of jargon and acronyms

3.1.1 Principles Underlying the QSCIS Model of Care

The QSCIS Model of Care model is underpinned by the following 6 key principles:

1. Patient Centred Practice: Services provided to people with a spinal cord injury will be patient centred and sensitive to their needs. This is an approach in which patients are viewed as a whole ensuring that an individual's intellectual, cultural and religious needs and preferences are accommodated as part of their individualised rehabilitation program. Patients and their families are actively involved in the planning of their rehabilitation, the setting of rehabilitation goals and in optimising their recovery and lifestyle following a spinal cord injury. The model provides the opportunity for choice and control by the patient by including flexibility for those who wish to have greater autonomy and direct services or for those who wish to receive more direction. We keep the patient and their world at the centre of the rehabilitation journey.
2. Maximising Function and Independence: Patients, their families and carers receive services that promote health independence and wellness.
3. Equitable Access: QSCIS shall meet the service element of access and equity through a strong triage and admissions policy, equal access to acute inpatient and rehabilitation processes and services, transitional, outpatient and outreach services. QSCIS ensures timely access to written and web based information for patients, carers and families including links to peer support.
4. Evidence Based Practice: QSCIS delivers services based on evidence of what is effective in order to improve patient care and experience. Patients and their families and carers receive services where practice meets quality standards, based on the best available evidence and delivered in a timely manner.
5. Interdisciplinary Care Teams: Patients have access to a core team who work collaboratively within an interdisciplinary framework. Teams use an integrated approach where all members (including the patient), actively co-ordinate care and services across disciplines based on best practice. All team members are of equal standing, contributing according to their areas of expertise.
6. Leadership: QSCIS Promotes active leadership of the patient in managing their health care and their rehabilitation journey in partnership with rehabilitation team members

3.2 QSCIS Governance

QSCIS operates under the Queensland Health Clinical Governance Framework which is operationalised at the service level. QSCIS is committed to transparency and accountability; improving its performance in patient safety and communication; and the concept of continuous quality improvement.

Overseeing the operations and performance of QSCIS is the service's management team. The management team is led by the Director of QSCIS and consists of the Nurse Unit Manager (NUM), allied health team leaders from within the Spinal Injuries Unit, all Staff Specialists, the Managers of TRP and SPOT, the Nursing Director Division of Rehabilitation, Nurse Educator, Clinical Nurse Outpatients, Peer Support Coordinator and the Medical Chair Division of Rehabilitation. This team meets on a monthly basis and is responsible for the leadership, strategy and priorities of QSCIS. They explore ways and means to enhance efficiency and ensure the future sustainability of services here at QSCIS. The collaborative efforts of this group:

- ensure the development and implementation of the business plan and budget
- ensure that service activities show continuous quality improvement
- and identify changes that are necessary to achieve the service's mission and values

Every leader within QSCIS has extensive experience within their relevant field in the delivery of healthcare services and in the management of teams. Each allied health discipline within SIU is headed by a team leader, the medical team is led by the Medical Director and the nursing team is led by the Nurse Unit Manager. The TRP and SPOT services have designated managers who lead their respective interdisciplinary teams. Each leader/manager is responsible for the implementation of the QSCIS business plan, discipline budget and the performance and development of their individual teams.

An Operations Team at the Spinal Injuries Unit meet on a monthly basis to discuss the operational aspects of service delivery specific to the unit. This team is comprised of the Medical Director, Deputy Medical Director the NUM and team leaders of each allied health discipline. The SPOT and TRP Managers meet with their respective teams on a regular basis to drive the operations of their service and discuss client caseloads where appropriate.

3.3 Staff Support and Education

The goals of QSCIS in relation to staff support and education are to:

- ensure an environment that promotes the provision of best practice in spinal cord injury rehabilitation
- facilitate open inter and intra-disciplinary communication that ensures effective interdisciplinary team functioning.
- provide strategic advice regarding resource allocation to key stakeholders
- ensure an environment that promotes job satisfaction for all through ongoing education and skill development support

As QSCIS offers a state wide service, staff hold and further develop specialised skills in providing services to this patient group. There is a strong focus on providing ongoing education at both a discipline specific and service level. Staff are provided with an induction program within their own discipline as well as a service wide orientation program. Staff from every discipline come together

once a month to attend QSCIS education and in-service. In addition the team is involved in a quarterly case reflection as this ensures we continually revise practices within the service.

The Spinal Injuries Unit supports on site educational placements for external students. The medical team provides training opportunities for University of Queensland medical students and rehabilitation trainees of the Australian Faculty of Rehabilitation Medicine. In addition, each of the disciplines offers the opportunity for Australian University students to do their educational placements.

At SIU the nursing discipline has a dedicated role for nurse education and a full time clinical facilitator to induct and train newly appointed nursing staff, up skill existing staff and provide mandatory training updates. Specialised training is offered to staff who take up the role of Rehabilitation Facilitator and there is clear procedure for identifying and training new Rehabilitation Facilitators.

The following principles underpin staff rehabilitation practices:

- occupational health and safety issues for staff working in QSCIS should be fully identified and policies and procedures for ensuring staff safety are put in place.
- patient, carer and staff safety in providing a rehabilitation service should be assessed on admission to the service.
- staff should be provided with adequate resources to provide a safe rehabilitation service

For QSCIS staffing profile see Appendix 1

Spinal Injuries Unit

Model of Care

4. The Spinal Injuries Unit

The Spinal Injuries Unit is a 40 bed unit located at the Princess Alexandra Hospital, in close proximity to all other acute medical and surgical services that are required to successfully manage a person with spinal cord injury. Rehabilitation services are provided by an experienced and professional inter-disciplinary team.

It is the only Spinal Injuries Unit in Queensland and one of the few Spinal Injuries Units in Australia that provides acute care, primary rehabilitation, transitional rehabilitation, outpatient services and outreach services from the one service.

4.1 The Rehabilitation Team

At the Spinal Injuries Unit, rehabilitation is based on a model of collaborative interdisciplinary care, operating within a holistic framework to develop rehabilitation plans in collaboration with the patient and their family. It is an integrated approach where all team members (including the patient), actively co-ordinate care and services across disciplines based on best practice. Interdisciplinary care allows for appropriate use and focus of the expertise of a mix of health care professionals. All team members are of equal standing, contributing according to their areas of expertise. This approach ensures an organised division of labour, working towards a common goal where there is a group responsibility for the final outcome.

The core interdisciplinary team consists of rehabilitation physicians, trainee rehabilitation registrars, residents, rehabilitation nurses, physiotherapists, occupational therapists, leisure therapist, social workers, and psychologists. The majority of these staff provide a service five days per week with the exception of rehabilitation nurses who provide services twenty four hours a day. The team is further enhanced by consultation when required with other health professionals including speech pathology, pharmacy, dietetics, stoma therapy and visiting medical specialists including a urologist, psychiatrist, plastic surgeon, neurosurgeon, pain specialist, respiratory physician, infection control specialist and orthopaedic surgeons. Peer support officers are regularly available on site, a service currently provided by Spinal Life Australia.

All staff within the unit are aligned to a consultant group and there are four rehabilitation teams within the spinal injuries unit. All teams deliver service to patients undergoing primary rehabilitation and those admitted for treatment of complications of their spinal cord injury.

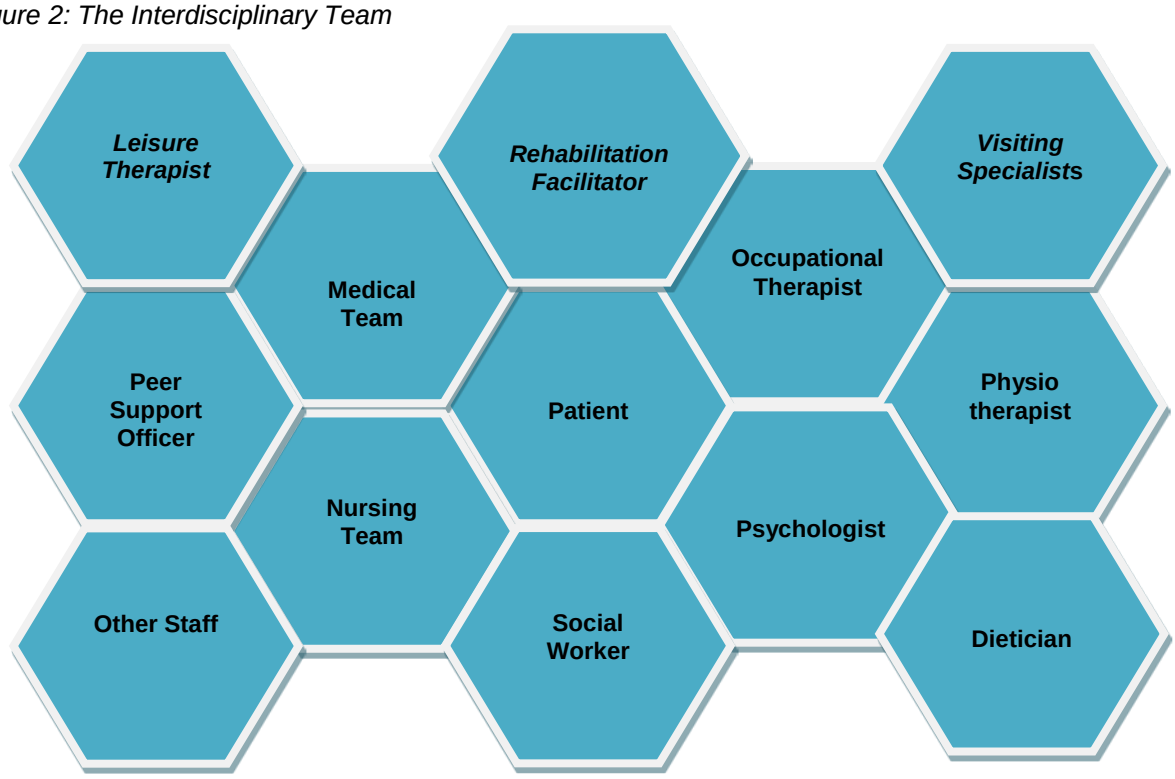
The team works with the patient, family and carers in establishing goals to maximise an individual’s independence and function. The majority of core interdisciplinary team members act as Rehabilitation Facilitators who coordinate services with patients. This is not a standalone role. The positive outcomes of using interdisciplinary teams are viewed as greater team collaboration, easy identification of interdisciplinary team members by patients and greater accountability by the team for patient outcomes.

For detailed descriptions of the core interdisciplinary team roles see Appendix 2.

The team takes every opportunity to ensure communication within and between disciplines is effective. Each discipline holds their own team meeting to organise work schedules, discuss professional development, policies and procedures and address any individual team issues that may arise.

For interdisciplinary team communication points see Appendix 3.

Figure 2: The Interdisciplinary Team



4.2. The Patient Journey and Rehabilitation Pathway

At the SIU the journey through rehabilitation may be different for each individual depending on their unique needs. The primary aim of the rehabilitation process is to maximise independence for each individual within the context of their individual goals, their environment and their level of injury. Rehabilitation requires consideration of the whole person, their physical, psychological, vocational and social background. The rehabilitation process is a goal directed, and time limited process aimed at reaching maximal independence in line with the injured patient's wishes.

At the SIU, rehabilitation begins on day one. From the initial assessment and diagnosis of spinal cord injury, individuals are exposed to a period of new learning around many aspects of injury, health and lifestyle management. The individual with spinal cord Injury is offered a supportive service by QSCIS through every phase of the recovery continuum. This includes intensive support through the primary rehabilitation phase, the transition to community; and lifelong follow up through spinal outpatients and the spinal outreach team.

Once a patient referral to the Spinal Injuries Unit is accepted, the patient is admitted either as an acute or rehabilitation patient. To cater for patients who are admitted under an acute stream, the unit is equipped with a six bed acute care facility which provides targeted care to patients who require intensive medical monitoring and review until deemed medically stable.

For details on SIU admissions policy and criteria please see Appendix 4.

4.2.1 Patient Orientation

The newly admitted patient is allocated a consultant rehabilitation team and a rehabilitation facilitator who together with the social worker and admitting nurse provide a comprehensive orientation for the patient and their family which takes place over a seven day period. An orientation procedure provides staff with a guide to the patient orientation process and there is an orientation checklist to ensure all relevant and essential information is provided. It is the Rehabilitation Facilitator's role to provide a smooth welcome and transition for each new patient attending the spinal injuries unit. The patient is provided with an information kit referred to as a 'Patient Portfolio'.

4.2.2 Assessment

For a patient with spinal cord injury, prompt and accurate assessment is crucial. The initial assessment of the patient admitted to the SIU therefore involves:

- medical assessment including neurological impairment status, pain levels, bladder and bowel function, routine bloods, repeat spinal x-rays to check spinal alignment following surgery, baseline renal surveillance imaging and urodynamics studies of the bladder as indicated
- nursing assessment including skin, respiratory, pain management, bowel history and bladder management
- physiotherapist assessment including respiratory function, neurological function, skin and range of motion
- team assessment including an ASIA impairment scale and a FIM score

Following initial assessment, plans are developed to manage immediate interventions and may include but are not limited to:

- medication and pharmaceutical approaches
- infection control precautions
- pain and symptom management
- nursing care plan including nutrition planning

Each of these approaches works towards enabling the patient to attend therapies by becoming medically well and developing a sitting tolerance. Once a patient is medically stable they are monitored on a regular basis by their medical consultant at a weekly ward round and as required if their medical condition changes.

4.2.3 Individualised Rehabilitation Programs

Therapy services in the physiotherapy gymnasium and occupational therapy departments are offered 4.5 days per week between the hours of 9am to 4pm on Monday to Friday with the exception of Wednesday afternoon when formal therapy services cease to allow patients the opportunity to attend sport and leisure activities. Ward based therapy for acute patients is usually attended to from 8am prior to other patients that are seen in the therapy areas. Individualised therapy programs are driven by the patient's identified goals, level of injury and length of stay.

At the SIU, goal planning processes are an important part of ensuring that patients individualised needs are incorporated as part of the rehabilitation pathway. The Rehabilitation Facilitator has an important role in organising and facilitating Patient Centred Rehabilitation Meetings (PCRM) and in further ensuring that the rehabilitation team maintains the key philosophies of interdisciplinary team work and patient-centred goal planning processes.

4.2.4 Patient Centered Rehabilitation Meetings

The first of the Patient Centred Rehabilitation Meetings is referred to as the Introduction to Rehabilitation Meeting (IRM). Wherever possible the Introduction to Rehab Meeting is scheduled as soon as possible from the date of the patient's admission. The ideal timeframe is within 2 weeks of admission but is dependent on the patient's individual needs and medical and psychological wellbeing.

The purpose of the 'Introduction to Rehabilitation Meeting' is to:

- allow the patient and family to meet all members of the individuals treating team and to collaboratively set the scene for the patient's individual rehabilitation journey by introducing the concepts of goal planning
- provide an opportunity for the patient and family to share information about themselves, their interests and activities and to express their preferences for rehabilitation activities that they would like to work on
- create an opportunity for the team to provide information, feedback and education regarding results of assessments; predictions regarding future outcomes and prognosis; and to provide an initial estimate of discharge timeframes

In the two weeks following the IRM, the Rehabilitation Facilitator meets with the patient and their significant others to prepare the patient and family for their first goal planning meeting (GPM). The aim of this discussion is to ensure the patient understands the goal planning process, the patient has the opportunity to identify their goals for rehabilitation and the date for the first goal planning meeting is set.

Sometimes, depending on the patient's needs and readiness to participate in a goal based rehabilitation program an IRM and GPM are combined as part of the initial patient centred rehabilitation meeting.

Regular goal planning meetings allow the team to break down patient identified goals into activities with time frames for completion, assign responsibility for these activities and thus ultimately evaluate the patient's satisfaction level in achieving their goals. Service goals and discharge planning are frequently discussed at goal planning meetings. The discussions of these meetings form an individualised rehabilitation plan for the duration of the patient's admission.

The core team attends a GPM and the patient is provided with the opportunity to co-chair the meeting with their Rehabilitation Facilitator. Broader team members such as the speech pathologist, dietician, leisure therapist, TRP, representatives of NDIS,NIISQ and other service providers are also invited to attend depending on the identified patient's goals. Goal Planning meetings are held frequently throughout the patient's primary rehabilitation usually every 4 to 6 weeks. However, the frequency of meetings is individualised according to the patient's needs, available timeslots and length of stay.

For details on other patient rehabilitation activities please refer to Appendix 5

4.3 Preparing for Community

4.3.1 Discharge Planning

An interdisciplinary approach is used in discharge planning where all team members including the patient are involved in discharge planning. An interdisciplinary discharge checklist is used to ensure all essential planning is considered.

A preliminary estimated discharge date based on all available information at the time is provided to the patient and their family shortly after admission and the team works together with the patient towards this date. Discharge dates are frequently extended; this may be due to unexpected medical complications, delays in identifying suitable housing options or the availability of care providers in the patient's discharge location.

Each discipline prepares a discharge summary which is forwarded to relevant community based health professionals including the patient's identified general practitioner (GP). The patient also receives a copy of their medical and nursing discharge summaries on the day of discharge.

Every patient is encouraged to enter the next phase of rehabilitation offered by QSCIS's Transitional Rehabilitation Team (TRP). TRP staff are invited to attend each patient's final goal planning meeting and are provided with a copy of each discipline's patient discharge summary and a summary of the patient's goal record. Patients who opt not to engage in a TRP program are referred to the final phase of the QSCIS continuum, the Spinal Outreach Team (SPOT) for ongoing lifelong follow up.

During the patient's rehabilitation program, the rehabilitation team's Social Worker identifies the need for ongoing personal care in the community and the core team completes an 'Interdisciplinary Team Personal Care Report' (IDTPCR) which provides a snapshot of a patient's functional status so care planning can commence with the TRP nurse for submission for ongoing funding. If required, training for personal care agencies in a patient's individual care routine can be provided in the ward environment.

The Outpatients Department of the Spinal Injuries Unit is made aware of the patients discharge date and where practical a follow up six week appointment is made with the treating Consultant.

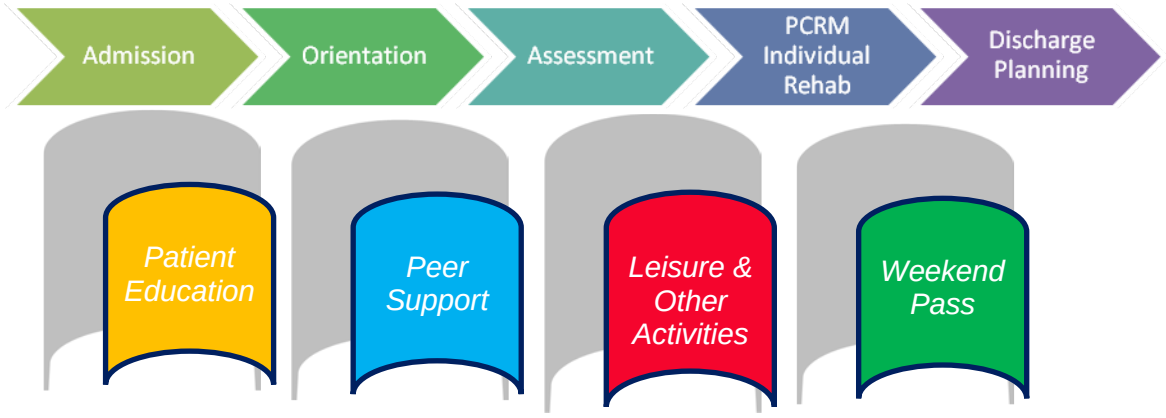


Figure 3:The Patient Rehabilitation Pathway

4.3.2 Outpatient Services

The Spinal Injury Unit Outpatients Department offers a range of general and specialty outpatient clinics for the ongoing follow up of people that have sustained a spinal cord injury. There are a range of specialist led general clinics as well as more specific focus clinics such as:

- Urology
- Spasticity Management
- Sex & Fertility
- Upper Limb Clinic
- Plastic Surgery
- Adult Spina Bifida

All new patients and any existing patients that have not been seen at the clinic in the preceding twelve months require a written referral from their GP (general practitioner).

4.3.3 Funding Options for Patients

All patients coming through the Spinal Injuries Unit at Princess Alexandra Hospital will have a funding option explored that will support equipment, care needs and changes to their housing

situation. Identifying appropriate funding options, and establishing the funding pathway early is part of the rehabilitation and discharge planning process. Funding options are: the National Disability Insurance Scheme (NDIS), the National Injury Insurance Scheme Queensland (NIISQ), Workcover, other compensation, insurance or common law, My Aged Care or the Spinal Cord Injury Response (SCIR).

SCIR is a collaborative program consisting of government agencies including Disability Services, Department of Housing, Medical Aids Subsidy Scheme and Queensland Health. The initiative has been designed to encourage individuals to build networks of support and to access a range of options within the local community. The SCIR program will be progressively phased out over the period of the NDIS rollout in Queensland, and will cease to exist from 1st July, 2019.

To be eligible for SCIR, the person with a spinal cord injury must:

- have a newly acquired spinal cord injury and be discharged from the Spinal Injuries Unit at the Princess Alexandra Hospital
- be a permanent resident of Queensland
- meet the specific eligibility requirements of, Department of Housing and Disability Services to be eligible for that department's contribution to the initiative

The funding can be broken down into three areas: equipment, housing/home modifications and care packages.

Equipment

The Spinal Cord Injuries Response (SCIR) New Equipment Program provides one-off set-up assistance to individuals with new spinal cord injuries following their primary rehabilitation in the Spinal Injuries Unit (SIU). Queensland Government funding is available for essential equipment items that allow individuals to live as independently as possible, and where specific equipment items may reduce the amount of personal care support required. All equipment provided is based on an individual's functional needs as determined by the prescribing therapist within the treating rehabilitation team at Queensland Spinal Cord Injury Service (QSCIS). Ongoing essential equipment needs and replacement of essential items for this group of patients is funded under the Medical Aids Subsidy Scheme (MASS) when their equipment meets the end of its serviceable life.

Housing/ Home Modifications

The Spinal Cord Injuries Response (SCIR) Home Modifications program provides assistance with essential home modifications for individuals with new spinal cord injuries for discharge following their primary rehabilitation in the Spinal Injuries Unit (SIU). SCIR funding is available for essential home modifications allowing individuals to return to their home environment. An example is bathroom modifications and ramps. All funding for modifications under SCIR are approved by the

Department of Housing (DOH) Queensland on a case-by-case basis based on an individual's essential functional needs. QSCIS employs a Housing and Home Modifications Occupational Therapist to assist patients going through this process and liaise closely with the Department of Housing. The SCIR Home Modifications program is not available to patients who reside in areas where the NDIS has rolled out.

Personal Support

A patient focussed, co-ordinated interdisciplinary approach assists in developing a care plan that maximises potential, independence and participation. The SIU Social Worker and TRP Clinical Nurse share the responsibility of personal care planning, and may request additional information to clarify needs and assist in accurately planning the needs for discharge. Until the NDIS rolls out fully, ongoing personal care for patients under the age of 65 at the time of their admission to SIU is funded by Disability Services. Funding is based on essential needs within the available resources of the program. For patients over the age of 65, funding for personal supports is provided by the Commonwealth's My Aged Care program.

Transitional Rehabilitation Program

Model of Care

5. The Transitional Rehabilitation Program

The Transitional Rehabilitation Program (TRP) model was developed in recognition of the fact that a rehabilitation program for people with spinal cord injury, delivered entirely within the context of a hospital environment, did not fully meet the needs of the individual, their significant others or the community in successfully assisting the individual to return to community living and their meaningful life roles. The TRP mission is to assist individuals with new spinal cord injury in their transition from hospital rehabilitation to community living through the delivery of specialist, community-based, time limited, goal directed rehabilitation programs.

The Transitional Rehabilitation Program assists individuals to consolidate and build on the skills developed in the Spinal Injuries Unit with the support of an experienced team of health professionals. The program actively encourages the involvement of family, partners and friends in these programs.

The Transitional Rehabilitation Program model delivers rehabilitation services to clients of the Spinal Injuries Unit either in their own homes or in a homelike setting outside of the hospital environment. The program allows individuals to re-establish family relationships that may have been disrupted by lengthy periods of hospitalisation. It enables individuals to begin to regain some control and direction in their lives and to enhance the physical skills required to live at home and in the community, as well as providing individuals with a more challenging rehabilitation environment, better quality of life and enhanced outcomes.

The Transitional Rehabilitation Program is staffed by an interdisciplinary team consisting of Nursing, Physiotherapy, Occupational Therapy, and Social Work professionals, with a rehabilitation registrar that is shared with the Spinal Outreach Team.

For individuals within the Brisbane metropolitan area, the Transitional Rehabilitation Program services are provided in the client's homes if practicable. Individuals who live outside the Brisbane area are able to complete their rehabilitation in one of three community dwellings provided by the Transitional Rehabilitation Program for the duration of the program. These are wheelchair accessible dwellings located in the suburban areas of Brisbane. Individuals are able to live in these houses with their own families or significant others whilst participating in the Transitional Rehabilitation Program.

TRP is designed to relocate the final weeks of rehabilitation from hospital to the community, and should therefore shorten SIU length of stay. TRP is promoted as the next "normal" stage of rehabilitation, rather than an optional "add on".

5.1 Readiness for Transition to TRP

Generally individuals are ready for transition to TRP when:

- they are medically stable
- management plans are in place for bladder, bowel, pain, mental health and other relevant medical issues
- skin is intact
- major equipment items have been prescribed (mobility, pressure care, personal care)
- home environment is safe and manageable (home modification or housing plans in place with timeframes where required)
- personal care services are in place, carers +/- other supports have had initial training
- ongoing medical and allied health referrals are in place.

5.2 Key Objectives of TRP

The key objectives of TRP are to:

- establish a sustainable network within the client's local community to meet ongoing healthcare and other needs
- provide specialist education, hands-on training and support to family members, carers and health professionals
- empower the individual, through education, support and information provision, to become the expert in the management of complications relating to SCI, and their ongoing health maintenance
- promote participation within the individual's local community by assisting the individual to overcome identified barriers
- promote physical activity as an important component of health maintenance
- assist the individual to resume meaningful life roles, by assisting the individual to overcome identified barriers
- ensure that prescribed equipment is safe, meets the functional needs of the individual, and promotes independence and participation

5.3 Key Outcome Measures

The key outcome measures used by TRP are:

- Functional Independence Measure (FIM)
- Mobility Outcomes (COVS)
- Multidisciplinary Goal Attainment Measure (MGAM)

Spinal Outreach Team

Model of Care

6. The Spinal Outreach Team

The Spinal Outreach Team (SPOT) is committed to providing an expert outreach service to people with spinal cord injury throughout Queensland.

6.1 SPOT Objectives

SPOTs objectives are to:

- provide a person centred, goal directed service utilising the skills of a transdisciplinary health professional team
- reduce the impact of secondary conditions on people affected by spinal cord injury
- support family and friends of people affected by spinal cord injury
- support service providers working with people with spinal cord injury through consultation and education
- maximise equity of access to specialist spinal cord injury services in Queensland
- identify, collaborate in, implement and disseminate research and service initiatives that benefit people affected by spinal cord injury

6.2 SPOT Principles

The SPOT model of service delivery incorporates the following principles:-

- a client focus
- participation and support of individuals significant to the client
- a holistic approach, incorporating the ICF Framework
- continuity of care and lifetime access to a specialised service
- equity of access
- early intervention through proactive service delivery
- facilitation of community integration and education of the local community regarding SCI
- liaison with, not duplication of existing services

The team aims to primarily perform a monitoring / early intervention and a consultancy / advisory role.

6.3 Monitoring / Early Intervention

All people discharged from the SIU, if in agreement, will be followed-up by telephone, or face to face, if necessary, at set periods by SPOT for the first 12 months after discharge from TRP or the SIU. The follow-up interview tool is based on the ICF to ensure a holistic assessment. Close monitoring by SPOT will facilitate the detection of problems quickly so that early intervention processes can be implemented. Clients will be encouraged to contact SPOT between follow-up phone calls if they require assistance or advice. A SPOT freecall 1800 624 832 telephone number facilitates this contact. This service supports and monitors not only people who had recently

sustained a SCI and who had been discharged from TRP or the SIU, but also people who have been readmitted to the SIU for complications such as pressure injury. Prevention of the economic and human costs of complications is the primary focus of this service.

6.4 Consultancy / Advisory Role

The SPOT service adopts a consultancy approach. A consultancy model not only enables limited team resources to cover a large area, but also facilitates the education and involvement of local service providers. Building the capacity of local service networks in SCI management helps address the issue of limited local expertise in the management of SCI which was identified as the major barrier to needs being met (Cox, Amsters, Pershouse 2001). People experience a wide variety of problem areas necessitating an approach, such as consultancy, which supports self management and is able to address a range of issues.

6.5 Interventions

Interventions entail goal directed episodes of care. Issues addressed are as individual as the clients who are referred. Issues may include equipment, splinting, counselling, respite, continence, mobility, exercise programs, skin care, relationships, or any other area within the expertise of the team. Thus, types of interventions and the method of implementing them will be determined by such factors as the nature of the client's problem, other agencies involved, the client's location and the best possible use of team resources. An important feature of the service is to use telephone and other telehealth methodologies as part of an overall strategy to ensure equity of access to all clients. Regional visits, and other strategies to maximise service availability across Queensland are included in more detail in the outreach visits section.

In keeping with an individualised approach, SPOT interventions occur in the most appropriate location within the limits of service resources. Therefore, interventions may occur at the client's homes, at work places, at equipment supplier's facilities, in SPOT office facilities, SIU outpatient clinics, local hospital and health services or in any community location which maximises the effectiveness of the contact.

6.6 Outreach Services

On a daily basis, the SPOT can visit clients within a 200 kilometre radius of Brisbane. Maximum equity of access for non-Brisbane clients is an objective of the service. There is no substitute for face to face contact with clients, carers and service providers in their own environment. Therefore, SPOT schedules a yearly timetable of regional visits to a minimum of 14 areas across the state. Regional visit durations depend on need but usually involve three (3) to five (5) days. A pre-planned yearly timetable enables all stakeholders to include specific visits in their planning and facilitates a proactive approach. A minimum of one visit per year to specific regional areas does not eliminate the need for support to these areas at other times but it will help to establish local support networks which will be used and supported as a resource for individuals with SCI living in the area, including people recently discharged from the SIU and TRP. Coordination of visiting

schedules with other services such as Spinal Life Australia's advisory service, the North Queensland Spinal Service and Lifetec maximise effectiveness and efficiency of visits. Regional visits for crisis intervention would be rare and methods such as videoconferencing offer an alternative in these situations as well as facilitating the expertise and involvement of existing services.

Specific procedures for regional visits have been developed with clients and local service providers being contacted in advance of the visit to enable prior planning and efficient use of time whilst in a non-Brisbane location. Comprehensive telephone assessment ensures that appropriate preparations can be made prior to the visit. Participation in planning by a representative from all the disciplines on the team enables individual team members to visit those clients, service providers and carers who require their specialist skills.

6.7 Education and Professional Support Services

The SPOT service utilises adult learning principles to meet a key objective of increasing the knowledge of the management of spinal cord injury, particularly secondary conditions of SCI and interventions aimed at improving quality of life, thereby building the capacity of health professionals and other service providers to assist people affected by SCI in the community.

SPOT provides professional education/development, through a variety of mediums (videoconference / face to face / lectures / joint consultations / web site), on topics related to the interdisciplinary management of spinal cord injury to address identified learning needs including:

- skin care and pressure ulcer management and prevention
- secondary conditions following spinal cord injury
- adjustment following spinal cord injury
- impact on significant others
- posture and seating
- ageing and spinal cord injury
- upper limb management

6.8 Research and Evaluation

The SPOT has a strong focus on service evaluation and has a significant research program. SPOT's major research achievement is the longitudinal Long Term Outcomes in SCI study. SPOT's research activities focus on areas that will translate into service improvement and have included:

- reducing the incidence, severity and life impact of secondary complications experienced by people with SCI
- exploring the factors which impede or facilitate societal participation for people with spinal cord injury in the early phase post discharge from hospital

- gaining insight into the role played by significant others in the lives of people with SCI
- clinical knowledge translation through consultancy

6.9 Scope

Who can use the SPOT service?

- People with spinal cord injury who have been formally accepted as clients of QSCIS. (This includes past patients of the SIU (initial admissions and readmissions at discharge), people with SCI who are past patients of other specialist SIUs and who have moved to Queensland from interstate and people who have been followed-up on an ongoing basis at SIU outpatient clinics.)
- Family and friends of people with spinal cord injury.
- Health professionals or service providers working with people with spinal cord injury.

Referrals will be accepted from any source as long as the client is agreeable and is within the scope of the service. Common referral sources are:

- self-referral
- at discharge from the SIU and TRP
- SIU outpatient clinics
- telephone/written referrals regarding people with SCI living in the community, from carers, health professionals and service providers

6.10 Staffing Profile

Service Manager

A service manager with clinical experience in SCI, from one of the above professions, and with relevant management experience is essential to effectively manage the service. Responsibilities include a 0.4 FTE clinical caseload to ensure that relevant clinical issues remain a focus of the service. This 0.4 FTE is included in the total clinical hours for that discipline.

Clinicians

Since the service has a high consultancy component, it is essential that all team members have expertise in the SCI area, thus HP5 and NGR7 level and senior registrar trainee positions are essential to attract and retain the appropriate staff. The proportion of each discipline reflects the higher demand for physiotherapy services and there is currently clinical nursing services offered in SIU outpatients.

Research Officers

SPOT's research program requires leadership by a senior research officer with relevant postgraduate research qualifications (i.e. Research Masters or PhD) and a degree in an eligible Health Practitioner discipline. A strong focus on service evaluation is also required to continue enhance the SPOT service delivery model.

Administrative Officers

AO4 Office Manager shared with co-located community services of TRP and ABIOS assist with organizing regional visits, videoconferencing scheduling, ordering and monitoring of supplies. The AO3 staff member would be responsible for reception duties; data entry; typing of reports; and formatting of educational materials.

For staffing profile see Appendix 1

6.11 Location of the Service

The SPOT service model is committed to providing a community based service model and location in the community is an essential component of this. To support SPOT's outreach program funding for travel including 3 cars with mobile phones for community visits is required. A small amount of specialized equipment and clinical consumables is required to support specialized interventions.

Appendix 1 – QSCIS Staff Profile as at June 2018

Spinal Injuries Unit		Transitional Rehabilitation Program		Spinal Outreach Team	
Medical	8.6 FTE	Manager	1.0FTE	Manager	1.0FTE
Nursing	96.05 FTE	Clinical Nurse	1.6FTE	Clinical Nurse Consultant	1.5FTE
Physiotherapist	6.0FTE	Physiotherapist	1.5FTE	Physiotherapist	2.7FTE
Physiotherapist Assistant	1.5FTE	Occupational Therapist	1.5FTE	Occupational Therapist	2.2FTE
Occupational Therapist	4.5FTE	Social Worker	1.0FTE	Social Worker	1.5FTE
Occupational Therapy Assistant	1.5FTE	Therapy Assistant	0.5FTE	Therapy Assistant	0.2FTE
Leisure Therapist	1.0 FTE	Research Officer	0.5FTE	Senior Research Officer	0.4FTE
Mobility Aids Officer	0.5FTE	Administration	0.5FTE	Research Officer	0.4FTE
Psychology	1.0FTE			Administration	0.5FTE
Social Worker	3.5FTE	Rehabilitation Registrar	0.5FTE	Rehabilitation Registrar	0.5FTE
Administration	3.0FTE				
Sport & Recreation Officer	0.2FTE				

Appendix 2 - SIU Core Team Role Descriptions

1. The Role of the Rehabilitation Facilitator

To best facilitate a co-ordinated approach to patient care at the Spinal Injuries Unit, the Rehabilitation Facilitator is accountable for ensuring that the patient centred model of care is occurring and that all patients undertaking rehabilitation services with the Spinal Injuries Unit experience a personalised and co-ordinated approach to their rehabilitation.

The Rehabilitation Facilitator is the primary contact person for the patient and their family. The Rehabilitation Facilitator keeps in regular contact with the patient and their family to ensure that any issues arising as part of the patient's rehabilitation pathway are attended to. This may include referring them to another team member if you cannot assist them with their direct request.

There are four key areas of responsibility for the Rehabilitation Facilitator:

- orientating and welcoming the patient to the SIU
- co-ordination of Patient Centred Rehabilitation Meetings
- co-ordination of weekend leave
- Co-ordination of discharge summaries

The role is not a standalone role but is incorporated into the duties of an identified key rehabilitation team member from the patient's core rehabilitation team. The team member fulfilling this role may be from any of the disciplines within the unit.

2. The Role of the Medical Team

The medical team is led by a Medical Director and comprises of Rehabilitation physicians, registrars in training and resident medical officers who offer comprehensive medical care across all facets of spinal cord injury both in an inpatient and outpatient setting. The Spinal Injuries Unit (SIU) has 40 inpatient beds that are distributed across the four rehabilitation specialists working as unique teams. Each specialist oversees approximately 10 patients and each specialist is equipped with unique skills to assist with the management of spasticity, sex and fertility, musculoskeletal and upper limb conditions as a result of spinal cord injury as well as in the management of adult spina bifida. The medical team is part of the interdisciplinary team at SIU who have a holistic, patient centred goal based approach to their practice and also offer their services to the community based Transitional Rehabilitation and Spinal Outreach Teams of the Queensland Spinal Cord Injury Services (QSCIS) through regular liaison. Weekly radiology meetings and rounds are also held at SIU by the Urology, Plastics and Orthopaedic services.

The SIU is recognised by the Australasian Faculty of Rehabilitation Medicine (AFRM) as an accredited training facility for post graduate training in Rehabilitation Medicine and has trained many rehabilitation specialists in spinal cord injury medicine over the years.

Specialists of the medical team are also active members of the Australasian Faculty of Rehabilitation Medicine (AFRM), Australia/New Zealand Spinal Cord Society (ANZSCOS) and International Spinal Cord Society (ISCOS).

Research which is aptly supported by an extensive in-house data base is encouraged in the medical team who have several publications and presentations to their credit. Rehabilitation physicians of the medical team hold academic titles at both the University of Queensland (UQ) and Griffith University Medical students from UQ are regularly placed for 6 weeks at SIU as part of the medicine in society training.

Regular outpatient clinics at SIU are run by the medical team consisting of specialist led general clinics to review both new referrals and follow up patients. In addition specialist spasticity, sex and fertility, musculoskeletal, upper limb and adult spina bifida clinics are held. Weekly on site urology and plastics clinics also take place.

3. The Role of the Nurse

Of all the rehabilitation team members, the nursing team has the greatest contact time with patients of the Spinal Injuries Unit, providing service across three shifts during a twenty four hour period. The Nurse Unit Manager, the Nurse Educator and Clinical Nurse Consultant along with a group of clinical nurses (10) make up the nursing management team. This team together with a large group of registered nurses, enrolled nurses and assistants in nursing are responsible for facilitating self-care and independence within the patient group. Working in collaboration with the interdisciplinary team, nurses encourage the patient and their significant others to see possibilities, explore opportunities and assist patients to work towards their rehabilitation goals.

The nurses' everyday role includes assisting patients with hygiene and personal cares; medication administration and education; positioning and skin care management as well as bladder and bowel management following a person's injury.

To best assist the patient, nurses are divided into the four rehabilitation teams. Within these rehabilitation team groups, smaller groups of nurses are allocated to assist with discharge planning and targeted education on managing the patient's spinal cord injury
The nursing team co-ordinate "The Living with Spinal Cord Injuries" weekly patient education series. SIU nurses promote self-determination and maximise education opportunities for patients. The SIU Nurse enhances the patient's potential for reintegration into roles in the community and assists the patient and their significant others with lifestyle adjustments.

4. The Role of the Social Worker

Social Workers in the Spinal Injuries Unit work with clients, their family and significant others to enable psychosocial adjustment and re-engagement with their community following a spinal cord injury. Social work interventions include:

- Undertaking psychosocial assessments and goal setting with clients, family and significant others

- Provision of therapeutic interventions including counselling
- Facilitation of discharge planning and the navigation of complex internal and external systems
- Supporting clients and family to access the necessary internal and external resources to enable optimal health, autonomy and participation.
- Provision of advocacy and negotiation on behalf of clients and their families within the hospital system, statutory institutions and other relevant agencies to optimise their outcomes and contribute to lifelong health and well-being.
- Provision of case management services, particularly in liaison with external government and non-government stakeholders including insurers and solicitors.

5. The Role of the Occupational Therapist

The Occupational Therapist assists each individual to set patient-centred goals in conjunction with the interdisciplinary team to promote a maximum level of independence in the areas of self-care, domestic duties, work and leisure.

An individual program is created to meet the patient's needs and may include:

- Upper Limb Management - Splinting and positioning; and use of functional activities to strengthen muscles, improve dexterity and develop hand function.
- Self-Care Retraining - Rehabilitation aiming to achieve maximum independence in everyday tasks such as feeding, grooming, bathing, dressing, bladder/bowel management and skin care.
- Domestic and Community Living Skills - Provision of opportunities to develop new skills and techniques to manage meal preparation, cleaning, laundry tasks, shopping, money handling and use of public transport.
- Home Assessment and Modifications - Identification of potential environmental barriers to hospital discharge and ensuring timely referral to an appropriate home modification service for assessment.
- Specialized Equipment Prescription - Trial, provision and/or prescription of adaptive equipment/aids and technology to facilitate independence in activities of daily living, as required for discharge.
- Return to Driving - Referral to appropriate driving assessment service.
- Vocational Skills - Support to pursue return to work or study options.
- Cognition - Assessment and implementation of strategies to minimise impact of any cognitive impairment on daily living.
- Other - Pain management, education, group programs and parenting.

6. The Role of the Leisure Therapist

Leisure Therapy treatment services are designed to restore, remediate and rehabilitate a person's level of functioning and independence in life activities, to promote health and wellness, as well as to reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disability. There is a specific focus on the holistic wellbeing and health of individuals through recreation and leisure with programs and interventions that have measurable outcomes.

Within the Spinal Injuries Unit Leisure Therapy Interventions can include:

- initial leisure therapy assessment and goal setting
- individual personal recreation programs
- leisure education and awareness
- leisure advocacy
- leisure modification
- creative and expressive recreation
- leisure based community integration
- reminiscence and re-socialisation
- provision of equipment
- leisure based stress management/relaxation

7. The Role of the Physiotherapist

The Physiotherapist in the Spinal Injuries Unit encourages and facilitates independence in movement and functional tasks and assists each patient to optimise their quality of life by enhancing their physical capabilities. Physiotherapy programs are designed to maximise every patient's ability to reach optimal levels of function and independence, participate in activities of daily living and will often involve their family and friends. Intervention begins in the acute care phase and continues throughout the rehabilitation process.

A physiotherapy program will involve:

- assessment of key impairments & their severity, activity limitations and participation restrictions
- setting jointly agreed goals to address these limitations and restrictions
- identifying, developing and administering treatments
- measuring outcomes and success

Physiotherapy interventions are most effective in the management of impairments that are directly or indirectly related to physical impairments involving motor and sensory loss. This includes the following areas:

- respiratory
- balance
- neurological
- posture

- skin
- tone/spasm
- joint range of motion
- strength and fitness training
- education provision
- mobility – in a wheelchair, walking etc
- functional skills such as bed mobility, transfers etc
- discharge planning
- assessment of equipment needs & prescription ie wheelchairs, cushions, exercise equipment, walking aids etc

8. The Role of the Psychologist

Major life changes are associated with spinal cord injury and the Psychologist works as part of the rehabilitation team to assist the patient and their family in transitioning through the period of new learning, adjustment, change and coping that follows after a spinal cord injury.

At the Spinal Injuries Unit the Psychologist meets with all patients to provide:

- an initial assessment of a patient's current level of coping and adjustment following their injury. This includes identification of social supports, coping skills and any psychological, behavioural or cognitive risk factors that may complicate the patient's adjustment to injury or impact on a patient's participation in the rehabilitation process.
- provision of intervention and treatment in line with the patients identified goals and support needs. This includes the provision of counselling and other patient-centred evidence based psychological therapies.
- education to the patient and family regarding the immediate and long-term emotional and behavioural consequences of spinal cord injury, traumatic brain injury or other neurological condition. The psychologist works with the patient and family with the aim to enhance the patient's independence and control over their physical and emotional health so as to maximise the patient's ability to resume meaningful daily activities following discharge.
- neuropsychological assessment, quantification and documentation of an individual's cognitive strengths and weaknesses following suspected head trauma or other neurological condition. This information can be used by the Psychologist and the wider rehabilitation team to clarify medical diagnosis and to guide recommendations for appropriate rehabilitation goal planning.

Appendix 3 – Table SIU Interdisciplinary Team Communication Points

Meeting Name	Purpose	Frequency	Duration
Operations Meeting	The Spinal Injuries Unit's operational management team is responsible for managing the day to day operations of the unit. This team is comprised of the Director SIU, the Nurse Unit Manager and team leaders from each allied health discipline within the unit. They provide leadership and make decisions on issues surrounding the day to day operations within the unit.	Monthly	2 Hours
Case Conference	Case conference provides the opportunity for each rehabilitation team to discuss collaborative approaches to providing rehabilitation to patients and make joint decisions on important issues.	Weekly	1 Hour
Admissions Meeting	The weekly admissions meeting provides an opportunity for the team to prioritise new patient referrals, allocate new patients to rehabilitation teams and discuss any necessary early intervention plans.	Weekly	30 minutes
Patient Centred Rehabilitation Meetings	PCRMs provide an opportunity for the rehabilitation team and the patient to discuss patient identified goals and collaborate on rehabilitation planning for the patient. There are ten one hour slots each week dedicated for PCRMs.	Weekly	1 Hour
ADL rounds	Activity of Daily Living (ADL) meetings provide an opportunity for the broader interdisciplinary team to discuss patient progress in relation to their functional status and current capabilities in their basic activities of daily living	Weekly	30 minutes
Patient Scheduling	Patient scheduling consists of daily meetings of representatives of nursing, physiotherapy, occupational therapy and social work to discuss the appointments that each patient is required to attend the following day. The daily schedule is then mapped out on the large white board at the main nurse's station. Patients are able to view the board after 4pm each day	Daily	15 mins
Interdisciplinary Team handover	Key team members from each discipline attend a daily morning handover given by the nursing staff to advise of important changes in patient's progress.	Daily	15mins

Appendix 4 – Admission to Spinal Injuries Unit

The Spinal Injuries Unit has a clear admissions policy and each referral to the Spinal Injuries Unit, is scored using an admissions matrix to determine priority for admission to the Unit. Individuals must be 16 years or older to be eligible for admission.

Individuals who have injury or impairment to the spinal cord as a result of an acute traumatic spinal cord injury may be admitted as an acute admission until deemed ready to participate in a rehabilitation program. Individuals who have injury, non-progressive disease or impairment affecting the spinal cord from traumatic or non-traumatic causes who are assessed as able to participate in a rehabilitation program are admitted via a rehabilitation stream. General exclusion criteria from admission are:

- individuals with malignant or metastatic disease or progressive spinal cord impairment
- individuals with cerebral or brainstem injury or disease resulting in tetraplegia
- individuals with diseases of the peripheral nervous system resulting in tetraplegia or paraplegia
- individuals with progressive neurological or neurodegenerative diseases affecting the spinal cord
- individuals with vertebral bony injuries only

A medical referral and an assessment by a Spinal Rehabilitation Consultant are required before admission to the Spinal Injuries Unit. Patients referred for admission where possible are reviewed in person by a Rehabilitation Consultant and the Clinical Nurse Consultant (CNC) prior to admission. The Consultant and CNC will assess suitability for admission, introduce the service and troubleshoot any issues that have or may potentially arise prior to a bed becoming available for admission. Once the referred patient has been reviewed their case is presented at the Unit's weekly admissions meeting for discussion on priority and allocation of an available admission date. At this meeting the referred patient is allocated a consultant rehabilitation team including a Rehabilitation Facilitator who acts as conduit for communication with the team and who coordinates the rehabilitation team's approach to a patient centred goal directed rehabilitation plan for the individual.

People who have had a previous spinal cord injury and who develop a complication that requires treatment in the Spinal Injuries Unit are admitted to the SIU depending on bed availability and on discussion with a SIU Rehabilitation Consultant. There are four allocated beds within the forty bed unit for patients requiring surgical intervention for the management of a pressure injury. These patients are managed by the Skin Management and Rehabilitation Team (SMART) during their stay at the Spinal Injuries Unit.

The requirements for repatriation of Queensland residents, who are injured in other regions, both nationally and internationally, are planned in consultation with the Spinal Injuries Unit Director.

Exceptions to the Spinal Injuries Unit Admissions Policy may be made in special circumstances at the discretion of the Spinal Injuries Unit Director.

Appendix 5 - Other Rehabilitation Activities

Rehabilitation Activities

Patient Pass	Patients are encouraged where possible to experience time away from the unit to practice their new found skills in their own home or simulated environment. This may take the form of a few hours leave, day leave, weekend leave or extended leave over holiday periods. The time spent on pass is often increased over a period of time beginning with a few hours leave and building on this as the patient and their family feels more confident. Leave from the SIU is approved by the team and coordinated by the Rehabilitation Facilitator using pre and post pass checklists. The rehabilitation team is responsible for ensuring the patient's health and skill level will allow them to cope in an external environment, the pass destination is safe and patients have appropriate loan equipment and pass medications where required.
Patient Education	The team endeavours to ensure the patient becomes an expert in understanding and managing their spinal cord injury. Patient education is an ongoing process throughout a patient's entire rehabilitation program with each member of the rehabilitation team providing individualised education sessions to the patient. The Living with Spinal Cord Injury Program is an eight module formal education program offered to patients on a weekly basis. Each week an education module is delivered by members of the team according to their area of expertise, as well as invited community stakeholders in a classroom style setting. Patients, their relatives and carers are encouraged to attend each session. The program is coordinated by the nursing team's Nurse Educator and Clinical Facilitator.
Peer Support	A team of four peer support officers, employed by Spinal Life Australia are readily available on site to patients throughout their primary rehabilitation. They enhance the formal rehabilitation process by offering information, support and mentoring through sharing their lived experience. Their interactions with patients are on an informal basis however appointments can be made. Peer support host regular group interactions where patients have the opportunity to hear about the broad range of services offered by the Spinal Injuries Association and meet Association staff.
Patient Forum	A patient forum is held once a month which provides staff and patients the opportunity to communicate on important issues that arise for patients in the rehabilitation setting. Important issues raised that require action are forwarded to the Management team for consideration.
Sport & Other Activities	Patients are provided with the opportunity to participate in sport and other activities on a Wednesday afternoon. These afternoons are coordinated by the Activities Coordinator who provides a program throughout the year including come and try sport days in association with Sporting Wheelies and other community based activities.
Staff Forum	A bi-monthly staff forum is held at SIU as a team building activity which QSCIS staff attend to receive service updates ,exchange ideas and network with one another

Useful Resources and Links

International Classification of Functioning, Disability and Health (ICF)
http://www.who.int/classifications/icf/en/

Clinical Governance
http://www.health.qld.gov.au/quality/clinicalgov/default.asp

EQuIP 4th edition; the accreditation standards from the Australian Council on Healthcare Standards (ACHS).
http://www.achs.org.au/EQUIP4/

Disability Services
http://www.communities.qld.gov.au/gateway

Queensland Spinal Cord Injury Services
http://www.health.qld.gov.au/qscis/

Spinal Life Australia
http://www.spinal.com.au/

National Disability Insurance Scheme
https://www.ndis.gov.au/index.html

National Injury Insurance Scheme Queensland
https://niis.qld.gov.au/

WorkCover Queensland
https://www.worksafe.qld.gov.au/

My Aged Care
https://www.myagedcare.gov.au/

WHO – Recommendations on Rehabilitation in Health Systems
http://www.who.int/disabilities/rehabilitation_health_systems/en/

Rick Hansen Institute – Access to Care and Timing
http://rickhanseninstitute.org/work/our-projects-initiatives/act/focus-issue

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