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Community Neurological Rehabilitation Team Interdisciplinary working

WMQRS Good Practice Event 7th June 2013

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Community Neurological Rehabilitation Team

- **Provides both Long Term Neurological Condition management and rehabilitation**
- **Separate to the stroke rehabilitation team**
- **Referrals accepted for all other neurological conditions aged 16+**
- **Community based with a mixture of domiciliary and rehabilitation unit based activity**
- **Patients not discharged from service, allowing easy ongoing access to all component parts of service as their needs change**
- **Notes are interdisciplinary and the same set used by all team members for clinic and domiciliary appointments**

Shared office space

- **Allows informal patient discussion on a daily basis**
- **Facilitates timely joint interventions**
- **Builds trust between team members**
- **Supports caseload management of busy clinicians – with consultation from senior staff, many lower level interventions can be carried out by another team member already involved with the patient, simplifying referral processes and consequently patient waiting time, and supporting professional development of staff.**

Simplified referral processes

- **Clinical Nurse Specialists and Rehab Consultant have access to appointment times for physiotherapy and Joint OT/Physio clinics. Patients are provided with appointment time and letter during the clinic, this reduced clinical time spent arranging appointments and reduced waiting time for physiotherapy review appointments**

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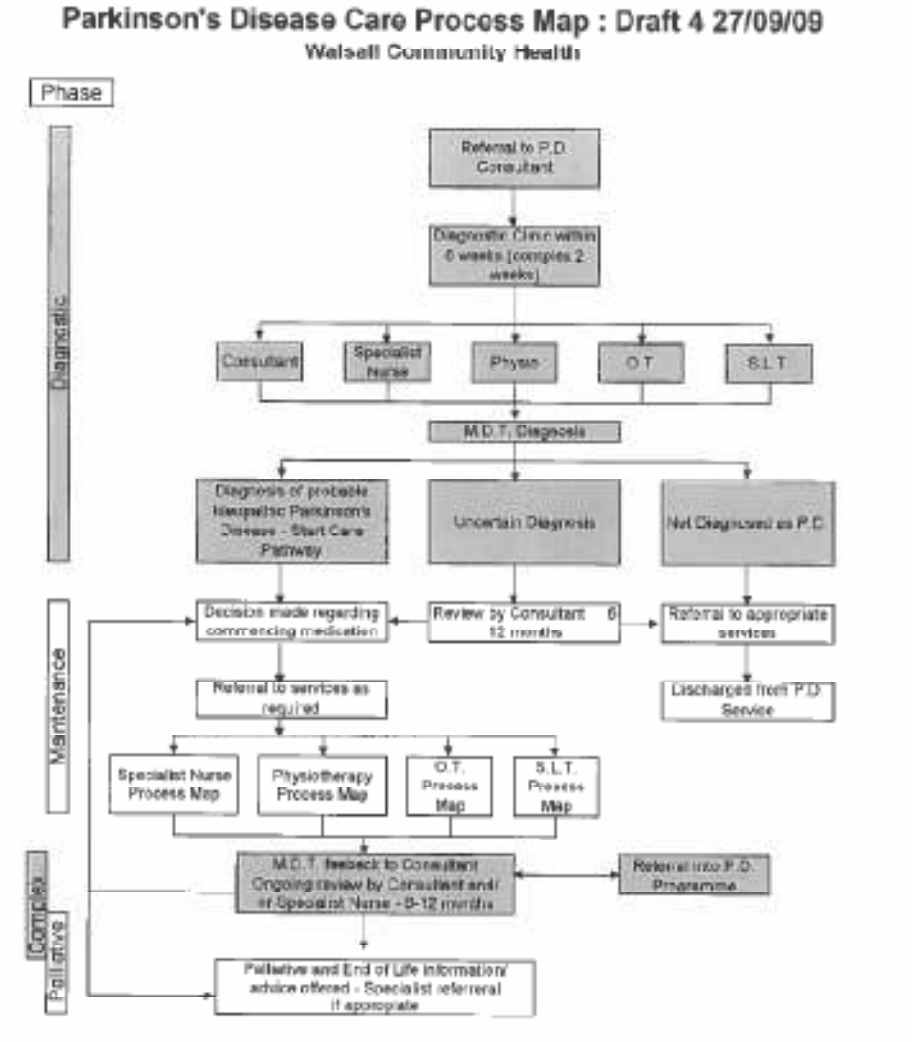
Joint working

- **Goal attainment scaling OT and Physiotherapist led clinics**
- **Multidisciplinary PD diagnostic clinic**
- **Bladder and bowel clinic with Rehab Consultant, continence nurse and assistant practitioner**
- **Joint MS clinic with MS CNS and Rehab Consultant**
- **Spasticity management clinic with Rehab consultant and Physiotherapist**
- **Joint home visits as required with all team members including rehab consultant**
- **Case conferences at patients home or in clinic**
- **Joint education programs – PD, MS adjustment, Fatigue management**
- **Joint goal setting and action planning with appropriate professionals**
- **Timely input for patient**
- **Patient knows who will be picking up follow-on actions after clinic**
- **Flexible approach, patients can be booked in to any clinic by any team member as required**
- **Weekly MDT meeting supports discussion of joint patients**

PD MDT diagnostic pathway



- **See back of sheet for full size flow diagram**

Joint health and social care working

- **A social worker with the Complex Team in Walsall Social Services, sits within the team's office at Darmouth House several days a week and attends MDT meetings. Since the review, she is now able to accept complex referrals straight from team members**

- **Maintenance therapy unit at Goscote Centre run by Social Care staff. Supports patients requiring ongoing maintenance therapy input to prevent or reduce complications of their LTNC. Care plans are devised, taught and monitored by the CNRT physiotherapists but carried out by social care rehab support workers. Programmes include use of standing frames, tilt tables and passive movements and often complement spasticity management interventions.**

- **Continuing Health Care nurses involved in care planning of complex CHC patients, sit with team in shared office enabling communication on care planning, joint visits and simplified referrals.**