### Summary of RHRU Integrated Care Pathway for people in Prolonged Disorders of Consciousness (PDOC)

**Regional Hyperacute Rehabilitation Unit, Northwick Park Hospital**

| Stage 1 (Day 1) | • Risk Assessment of Manual Handling, (transfers/positioning in bed)  
• Implement existing PEG feed regime and adapt feed as appropriate.  
• Implement existing trache care protocol (+risk assess).  
• Assess skin & breakdown risk. (Waterlow score). Turning chart commenced.  
• Review existing splints and wearing regime  
• Evaluate resus status and draw up plan of action in discussion with consultant and discuss with family as appropriate |
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| Stage 1 (Day 2) | • Review existing PEG feeding regimen and adapt if appropriate.  
• Review existing trache care protocol adapt if appropriate.  
• Assess skin integrity and review wounds and photograph.  
• Assess bladder and bowel function  
• Assessment of mouth care |
| Stage 1 (Week 1) | • Assess swallow function.  
• Assess passive range of movement/Spasticity Assessment.  
• Review Brain Imaging Scan (if already carried out). If not scan, Is Brain Imaging required?  
• Carry out brain stem reflex assessment  
• Review and identify medication that could be affecting arousal level  
• Assess for signs of HO. Is an X-ray Indicated or Bone scan  
• Commence WHIM (minimum 10 assessments within two-three weeks and at different times of day).  
• Commence sleep/wake chart (1 week).  
• If Tracheostomy in situ refer to Trache Clinic and review appropriateness for trache weaning  
• Confirm reason for admission (diagnosis of level of awareness , management and care needs) with family/N.O.K.  
• Give family communication questionnaire, service booklet, PDOC information leaflet  
• Identify need for skilled support for family  
• Monitor pain using behavioural assessment tool for patients in MCS |
| Stage 2 (Week 2) | • Complete PDOC interview and establish family's expectations, Goal Attainment Score goals  
• Establish postural management programme and guidelines (including seating and soft tissue management).  
• Referral to spasticity service (if applicable).  
• Assess level of awareness during tilt tabling  
• Individualised mouth care programme established.  
• Review sleep/wake cycle  
• Commence bladder and bowel regime  
• If patient has psychiatric history to consider use of depression scale in conjunction with behavioural pain scale  
• Invite family to complete checklist 2E |
| Stage 3 (Week 3) | • Review WHIM and agree other appropriate formal assessment to be completed such as CRS-R or SMART  
• Incorporate all routines into 24 hr programme (positioning, splints, mouth care) and include findings from communication Q into basic interaction programme.  
• Optimise pre-assessment external factors (medical stability, ear canal check, positioning, medication, Continence, nutritional status)  
• Review personal care and establish guidelines.  
• Provide verbal and written tracheostomy education to family |
| Stage 4 (Week 4) | • Ensure all 10 WHIMs completed  
• If starting SMART, meet family/NOK and go through lifestyle/history/ communication questionnaire and pre-assessment informs.  
• Referral to wheelchair service.  
• Review Bladder and bowel regime |
Stage 5 (Week 5)
- Commence SMART. (Week 1) and minimum 1 WHIM
- If SMART not appropriate complete
  - CRS-R x4
  - WHIM x1
- Team to discuss feasibility of Pharmacological Trial
- Team to review discharge date and options for discharge destination
- Key Worker to discuss discharge date/destination with family.

Stage 6 (Week 6)
- Continue SMART assessment. (Week 2) and complete WHIM x1
- If SMART not appropriate complete
  - CRS-R X3
  - WHIM X1
- Discuss Pharmacological trial with family (if appropriate)
- Discuss appropriate discharge destination
- Case Conference
- Key Worker and team to complete Continuing Health Care checklist, and commence LHNA form and DST.

Stage 7 (Week 7)
- Complete SMART Assessment (Week 3) and complete WHIM x1
- If SMART not appropriate complete
  - CRS-R X3
  - WHIM X1
- Commence Pharmacological trial (as appropriate) and assessment using WHIM
- Key Worker and team to complete Continuing Health Care, LHNA form and DST and send off.

Stage 8 (Week 8)
- Write up findings of SMART assessment (i.e. report) and treatment plan.
- Establish splinting regime for discharge.
- Continue Pharmacological trial with WHIM
- Document Formal assessment of Mental capacity in medical notes
- Information given regarding Court of protection/legal aspects
- Advice given regarding Benefits/Finance/medical retirement
- Complete WHIM x 1

WEEK 9
- Feedback formal assessment results to family regarding diagnosis and prognosis.
- Review 24 hour care programme and Interaction Programme.
- To consider if Best Interest meeting appropriate
- To give out Best Interest leaflet if applicable
- Review SMART treatment plan

WEEK 10
- Discharge Planning team meeting
- Finalise formal evaluation and record of diagnosis (Annex 2F)

Stage 9 (Weeks 9 & 10)
- Feedback to family re Pharmacological trial.
- Complete discharge report and care booklet (including Interaction/sensory stimulation programme)
- Complete page 2 formal evaluation (form 2f)

WEEK 11
- Seek feedback from family regarding the admission (Family satisfaction survey) and review GAS goals.
- Care booklet discussed with family and sent to next placement.
- Discharge report discussed with family and sent toreferrer, CCG, GP and relevant agencies

WEEK 12