Department Plan for Providing Care/Services
Patient Care Departments

Department: Rehabilitation Services: Persons with Spinal Cord Injury

I. Scope of Service
   Introduction: See Rehabilitation Center Scope of Services for details.

The Physical Rehabilitation Unit offers specific services for persons experiencing a spinal cord injury. The Physical Rehabilitation department is part of the individual's continuum of care that culminates with a re-entry program into the community or discharge to a community facility for safety, care, and/or continued therapy services. Outpatient therapy services, psychological support, medical and surgical care, emergency services are examples of ongoing services that may be provided within this health system.

The spinal cord injury populations served include:
- Trauma
- Infection
- Tumors
- Surgery

General exclusions with recommendations to other acute rehabilitation facilities include:
- Ventilator requirements
- Complete high thoracic injuries
- Complete cervical injuries

Admission criteria include physical impairments that limit functional activity and potential to benefit from individualized and interdisciplinary rehabilitative services. All patients must be neurologically and medically stable, alert, and willing to tolerate three hours of combined therapies per day. A physician order and referral is required for admission to the unit. The patient and family must have a discharge plan to return to home.

Inpatient services include Nursing Care, with a minimum of five days/week Physical and Occupational Therapy, Speech Language Pathology, and Recreational Therapy. Additional services include Social Services, Nutritional Services, Spiritual Care, Psychological Support, and management of their medical needs. All services are directed by a board certified Physiatrist who provides overall guidance of the patient's treatment plan.

When possible and appropriate, outdoor community activities and outings are included to encourage patients to resume activities in the community. All inpatient rehab based persons are encouraged to socialize and interact with each other and their families as part of their recovery process. These individuals may have a diagnosis of stroke, brain injury, limb loss, fractures and joint replacements, polyarthritis, guillain-barre, multiple sclerosis and Parkinson's disease.

For the person with a spinal cord injury the Inpatient Rehabilitation plan of care focuses on injury mechanics, bowel and bladder training, pulmonary function, skin and wound care, pain management, nutrition, psychological and social services support, patient and family education along with comprehensive discharge planning including community support and re-entry.

Functional planning includes ADLs, equipment and environment modifications, neuro-muscular re-training, assisted weight bearing, ambulation and interactive gaming. Special equipment, seating, or orthotics needs, beyond the scope of the professional staff, is coordinated with external vendors who then provide services on site or immediately post discharge. Supportive services for the person served and their family include but not limited to; spiritual guidance, financial support, behavioral health counseling, peer group(s) and comprehensive discharge planning. Follow-up patient care may be coordinated by the Physiatrist medical director in collaboration with the other physicians involved in the ongoing management of the patient's medical needs.
Medicare, Medicaid and most private insurance carriers are accepted. All private insurances are pre-certified prior to admission. Persons with limited or no healthcare funding are referred to Patient Financial Services to establish a payment plan or be considered for Charity Care. Patient Financial Services provides to each patient a written letter reviewing their carrier coverage as well as a contact person who can further assist them in insurance or financial questions.

II. Leadership/Staffing

The Physical Rehabilitation Unit leadership team includes the Director of Therapy Services, Clinical Nurse Manager and Therapy Manager. A Lead Therapist and RN Coordinator help to facilitate care for the patients on a daily basis. Additional members of the team include the Admission Coordinator who supports the intake and screening of all new admissions, Social Work/Care Manager who ensures continuity of care and the Prospective Payment System Coordinator (PPS) who ensures accurate documentation and transfer of information.

Other core members of the team include Physical, Occupational, and Speech/Language Therapists. A Recreational Therapist is a key member of the team caring for the spinal cord injury patient. The Recreational Therapist is focused on identifying the patient’s activities prior to the spinal cord injury and fostering interests which help to enhance the patient's sense of well-being and purpose. A goal for the spinal cord injury patient to recognize that even with a loss of function, the ability to have meaning and productive lives is still attainable. The Therapy staffing matrix is adjusted daily based upon the volume of new admissions and discharges.

The nursing team includes registered nurses and support staff specially trained to support the restoration and rehabilitation of the patient population. The nursing staffing matrix is reviewed by the unit charge nurse every 8 hours and adjusted according to patient census and acuity. The Therapy and Nursing matrices are available upon request.

With all patient and staff assignments, cultural diversity, language needs and/or patient/family staff dynamics are evaluated when assigning staff to the rehab person.

III. Qualifications of Staff

Educational opportunities are provided in a variety of methods: See Rehabilitation Center Scope of Services for details.

Education examples for spinal cord injury may include:

- Physiological changes
- Wellness and adaptive sports
- Wound care, skin assessment
- Bowel/Bladder Management
- Fertility
- Spasticity Management
- Pain Management
- Seating modification and selection
- Wheelchair or adaptive equipment selection and safety,
- Community resources and how to access,
- Autonomic Dysreflexia
- Comorbidities and their impact on the healing process

IV. Description of Communication/Collaboration/Functional Relationship with Other Departments and Services

Multidisciplinary team staffing sessions are held to review patient’s needs on a weekly, or as needed basis. Attendees at the team staffings may include pharmacy, nursing, therapy services, home care services, chaplain services, care management, dietitian, social services, and medical staff. Results from the staffing sessions are communicated with the person served, family and support systems at least weekly with the appropriate individual signing and stating that they have received the information.
Additional medical specialists for the person served will be consulted by the medical director or physician designate as needed. All service specialty providers are considered part of the patient care team and encouraged to participate in the daily staffing huddles and patient conferences. If attendance is not possible the provider is expected to communicate with the medical director or unit nursing/therapy staff. Contracted services may also be used for patient/family needs such as prosthetics, orthotics, seating modifications, or assistive technology.

Both Therapy and Nursing teams meet bimonthly to share information and make suggestions of ways to enhance the delivery of care. The bimonthly meetings allow disciplines to communicate and share ideas.

The Inpatient Rehabilitative Leadership team communicate to all team members through weekly e-mails with a summary of the past week’s events or general information. This method is utilized to ensure all staff members are aware of critical information.

When emergent medical care is necessary and is beyond the scope of the rehabilitation unit staff, a Medical Response Team (MRT) can be activated. Services from the acute care hospital respond and address the immediate need of the rehab person. This team can be activated by the unit staff, physicians, patients, or family members.

Persons served that require a higher level of medical care are transferred to the appropriate care level within the Rush-Copley Medical Center. The person served is discharged from the rehab unit with the ability to return once medically stable and able to meet the rehab unit admissions criteria.

V. Goals of Department/Service

We believe that turning disabilities into possibilities is our main goal. Our commitment is to continuously improve the health of our community, by identifying needs of our populations. While collaborating with our multidisciplinary team to improve the quality of life and well being of the person served, the organization also provides leadership and talent to achieve the vision of making the physical rehabilitation unit the best place in which to live, work, grow, heal and enjoy life.

VI. Plan to Improve Quality of Care
See Rehabilitation Center Scope of Services for details.

VII. Any Additional Standards of Practice Adopted/Adapted by Department/Service

We will be providing our persons with a spinal cord injury the following:

- A serene supportive environment
- Alternative therapies to support the patient and families with special needs such as animal assisted therapy
- Continuity of care by utilizing a consistent team of care givers.
- Critical thinking skills utilized for patient assessment and collaboration with the physician to optimize care
- Comprehensive approach to pain management
- Hourly rounding to ensure patient needs are met in a proactive manner.
- Environment which fosters understanding of spiritual and cultural needs. Language barriers are addressed using credentialed medical interpreters, Pacific Care phone service or Illinois Video Interpreter Network or IVIN