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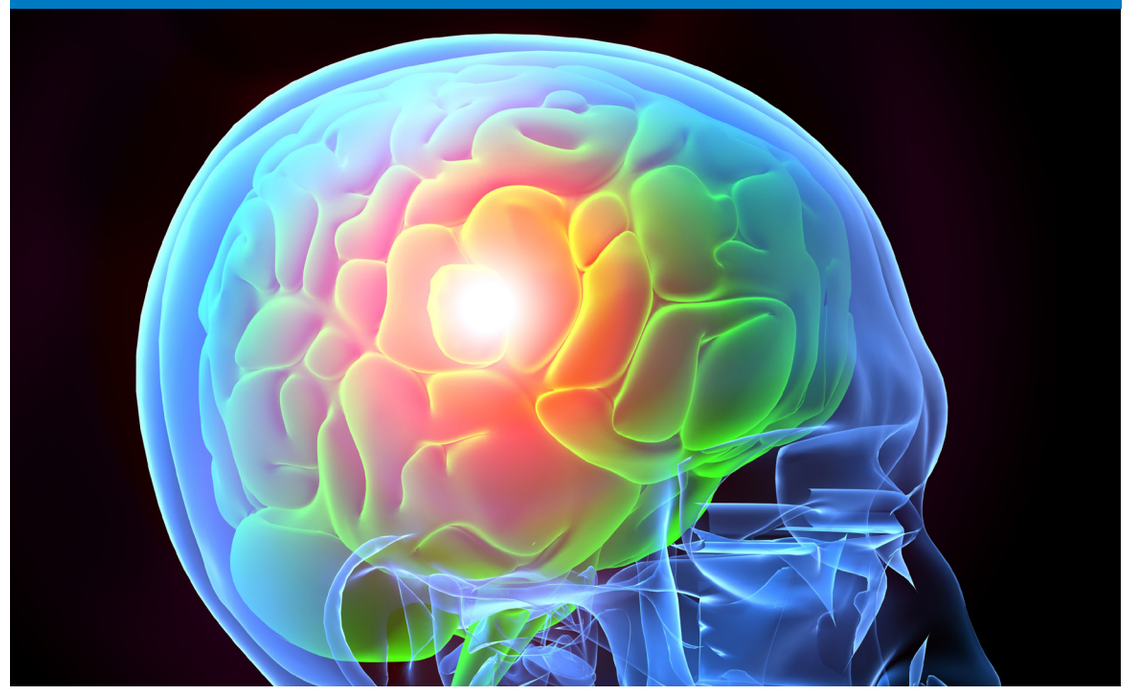
Greater Manchester Neuro-Rehabilitation
Operational Delivery Network

Developed by the Greater Manchester Neuro-Rehabilitation Operational Delivery Network (hosted by Salford Royal NHS Foundation Trust), in collaboration with patients, carers and clinicians.

Greater Manchester Neuro-Rehabilitation
Operational Delivery Network

Greater Manchester Neuro-Rehabilitation Services

information for patients and carers



Greater Manchester Neuro-Rehabilitation
Operational Delivery Network

www.gmnrodn.org.uk

@GMNeuroRehabODN

What is specialist neurological rehabilitation?

- A process of assessment, treatment and management
- Aim to help the patient achieve their maximum potential following a diagnosis of a neurological condition
- Provided by specialists in neuro-rehabilitation to ensure that all aspects of a patient's care are considered
- Provide treatment sessions to suit the patient's individual needs, but at the same time, meet their physical and cognitive (thinking) capabilities
- Rehabilitation works best if the patient fully participates in the program

Image Designed by kjpargeter / Freepik

What can the patient expect?

- The Greater Manchester Neuro-Rehabilitation Services support patients with neurological conditions throughout their rehabilitation journey
- Rehabilitation is different for everyone - it depends on a patients condition and their recovery. A patient may recover fully or may require assistance with activities in the future
- Rehabilitation can be provided in hospital or in the community
- Patients will be referred to the neuro-rehabilitation service that most suits their clinical needs
- Patients may require input from one or more neuro-rehabilitation services

Speech & language therapy

- Assess, advise and carry out personalised therapy for any communication difficulties the patient may experience
- Assess swallowing and eating problems and provide recommendations, strategies and therapy to maintain safe eating / drinking

Therapy & nursing assistants

- Continue treatments established by the team and often work with therapists and the nursing team to provide daily care

Dietitian

- Support with any concerns raised about the patient's weight or dietary intake
- Provide information on nutrition and help patients make informed choices about food and lifestyle

Social workers

- Support and advise on a variety of care packages depending on the patient's needs
- Complete assessments to ensure a safe discharge from hospital and make sure patients in the community have access to wider social systems

Family

- Attend various meetings where appropriate, and be involved in discharge plans
- Support from the patient's family / carers plays an important role in providing encouragement and helping the patient to stay positive

Patient feedback

We aim to provide the best service and value patient feedback.
The clinical team will ask the patient to complete a satisfaction questionnaire so please let us know how we can improve services or when we have done a good job.

@gmnrodn@srft.nhs.uk

0161 206 2109

Neuropsychology

- Help patients and their families recognise, understand, and cope with changes in a person's cognitive functioning
- Support patients and their families with common emotional and behavioural consequences associated with a neurological illness or injury
- Assess and support decision-making abilities

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Nursing team

- In hospital the nursing team assist and advise on most matters twenty four hours a day
- Assist with continuity of rehabilitation on the unit and ongoing patient goals
- In the community the nursing team will provide assessment, advice and support on neurological conditions and will liaise with other staff as required

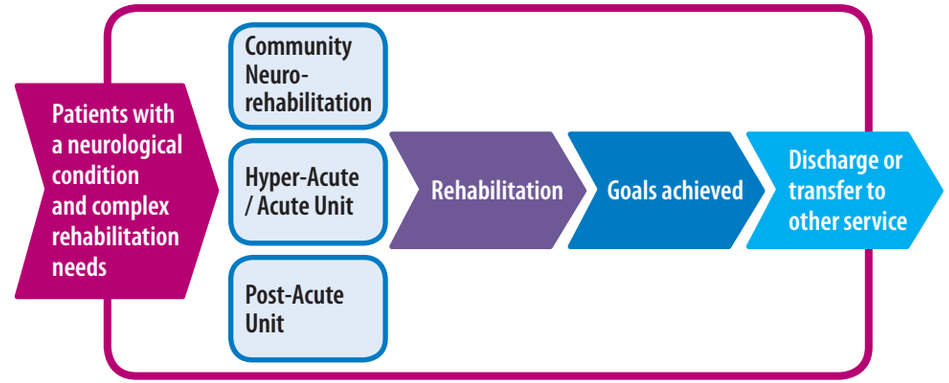
Occupational therapy

- Assessment and relearning of daily living skills
- Assess and provide cognitive rehabilitation
- Carry out home visits to assess the environment if required
- Organise equipment to the patient's home if required

Physiotherapy

- Assess and identify any physical impairments
- Implement an appropriate program of physical therapy in order to improve function
- Provide chest care including tracheostomy care in the hyper acute setting

Overview: Neuro-rehabilitation Model



The Hyper-Acute / Acute Neuro-rehabilitation Unit

The unit specialises in providing early specialist rehabilitation care for patients who still require a high level of nursing and medical input, as part of their rehabilitation programme.

Post-Acute Neuro-rehabilitation Units

The post-acute units deliver specialist assessment and rehabilitation. Whilst patients who access this service will be medically stable, the intensity of rehabilitation needs cannot be met by community services and their safety in the community would be compromised.

Community Specialist Neuro-rehabilitation Service

These services provide specialist intervention from many disciplines working in partnership with the patient and their family / carers to achieve their maximum potential. Rehab will take place in either the patient's home or their wider community setting.

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Community specialist neuro-rehabilitation services are not available in every part of Greater Manchester; ask your clinical team for more details.

Where possible, we will try to refer patients to their nearest service.

This cannot always be achieved and patients may be transferred to a service where there is availability.

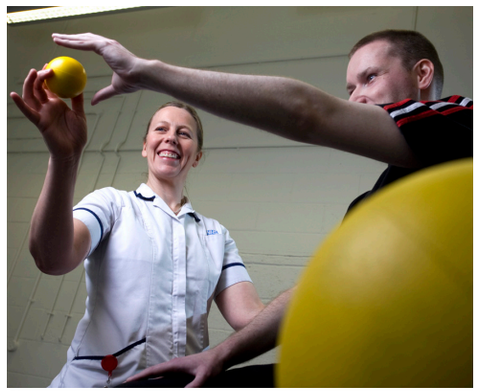
This is essential to ensure patients receive appropriate, timely rehabilitation and allow us to continue to provide specialist services.

Sometimes patients may need rehabilitation that is not provided by the NHS.

If this is the case, the clinical team will discuss this with the patient and their family.

What is goal setting?

- The patient will meet different healthcare professionals who will assess them to identify their rehabilitation needs and together, they will set realistic goals
- The team will assess a patient's progress towards their goals to determine when their recovery has been met or their care can be provided in an alternative setting



What is discharge planning?

In hospital:

- A **'key worker / lead therapist'** will be assigned to the patient who will update them and their family regularly regarding their progress and discharge planning. This will be a member of the clinical team
- The patient's clinical team will discuss with them how long they expect them to require the service; this may be referred to as 'expected date of discharge'
- Discharge planning may include plans for day leave or overnight stays at home
- If the patient has ongoing rehabilitation needs which can be met in the community or as an outpatient they will be referred to the appropriate service on discharge

Who may be involved in a patient's care?

The specialists involved in a patient's care will work together in order to provide them with the most effective treatment possible, specific to their needs.

The patient

- The most important person in a patients recovery
- A patient can aid their recovery by actively engaging in all their rehab programmes

Medical team

- In hospital this consists of neuro-rehabilitation consultants and other doctors
- Weekly ward rounds take place where the patient has the opportunity to discuss any medical aspects of their care
- In the community, the patient will have access to their GP and their consultant may continue to monitor their progress through outpatient clinics

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