MAJOR TRAUMA CENTRE MULTI-PROFESSIONAL CARE PLAN FOR SPINAL CORD INJURED PATIENTS

Summary of needs collated from patient assessments (multi-professional) and ongoing review of care plan and patient needs.
The assessments of patient should be used to inform the care plan and be reviewed regularly and updated

	Activity of daily Living (prompts for assessment)	*Please Tick*	Assessment of patient needs Record "no identified patient need" where this is the outcome of the nursing assessment	Date applicable to care plan	Signature of assessor
1	**Maintaining safety**				
	History/Risks of:				
	➢ Falls				
	➢ Seizures				
	➢ Allergies				
	Risk of Infections e.g. known MRSA/C.Diff				
	Requires regular clinical observations				
	Risk of Infections e.g. Cannula				
	Risk of VTE due to SCI				
	Known Vulnerable Adult				
	Reduced hand or arm function				
	Has a spinal cord or cauda equina injury				
2	**Airway and Breathing**				
	Respiratory support				
	Requires regular physio				
	History of chest infections				
	Shortness of breath				
	Smoker				
	Lung/heart disease/airway difficulties				
	Needs oxygen therapy				
	Inhalers				
	Nebulisers				
	At risk of sleep apnoea				
	Chest trauma				
	At risk of deterioration due to Spinal Cord Injury				
3	**Circulation**				
	Has a spinal cord injury above T6				
	Commence continuous cardiac monitoring				
4	**Communication/Dignity/Respect**				
	Hearing loss				
	Sight impairment				
	Speech/communication difficulties				

	English as foreign language				
	Memory loss				
	Impaired cognitive function				
	Known Dementia				
	Patient has Learning Disabilities				
	Behaviour which may be challenging				
	Has a spinal cord or cauda equina injury				
5	**Pain control**				
	Has a spinal cord or cauda equina injury				
	Patient is in pain				
	Chronic/long-term pain				
	Anxiety levels raised				
	Other discomfort				
	Activity of daily Living *(prompts for assessment)*	*Please Tick*	Nursing Assessment of patient needs (Record "no identified patient need" where this is the outcome of the nursing assessment)	Date applicable to care plan	Signature of assessing nurse
6	**Nutrition**				
	Has a spinal cord or cauda equina injury				
	At risk of malnutrition (MUST)				
	Patient Nil By Mouth				
	At risk of dehydration				
	Nausea/vomiting				
	Difficulty in swallowing				
	Needs assistance with feeding				
	Special diet e.g. Diabetic, low-fat				
	Intravenous fluids				
	Enteral feeding				
7	**Elimination**				
	Has a spinal cord or cauda equina injury				
	Is there evidence of urinary tract infection				
	Haematuria				
	Urinary incontinence/urgency				
	Urinary catheter/colostomy/urostomy				
	Needs a raised toilet seat/ equipment				
	Prone to constipation				
	History of diarrhoea				
8	**Personal hygiene**				
	Has a spinal cord or cauda equina injury				
	Assistance needed with bathing/washing				
	Assistance with oral hygiene needed				

	Assistance needed with basic footcare				
	Specific needs re privacy & dignity				
9	**Tissue Viability**				
	Has a spinal cord or cauda equina injury				
	The patient's skin is healthy				
	Skin dry/dehydrated				
	Pressure damage on admission				
	High risk of pressure ulcers				
	Evidence of other injury				
10	**Wound care**				
	Wound care plan needed				
	Wound chart/diagram				
11	**Mobility**				
	Has a spinal cord or cauda equina injury				
	Needs help with moving				
	Falls Risks				
	Moving & handling plan in place				
	Uses a mobility aids /wheelchair				
	Requires seating assessment				
12	**Emotional and mental well-being**				
	Has a spinal cord or cauda equina injury				
	Worries about condition/ treatment				
	Spiritual care/support needed				
	Concerns about home				
	Psychological support				
13	**Sleep**				
	Patient usually takes night sedation				
	Patient usually has nocturia				
	Patient has pain at night				
	Patient uses NIV				
	Patient reports reduced quality of sleep				
	Patient noted to snore				
	Patient having difficulty falling asleep				
14	**Collars/brace**				
	Collar/brace required				
15	**Management of the confused patient**				
	Signs of confusion				
16	**Management of patients at High Risk of**				

	Falls Has a spinal cord or cauda equina injury Falls risk assessment completed				
17	**Communication of care and treatment plans and discharge planning** Has a spinal cord or cauda equine injury				

MULTI-PROFESSIONAL CARE PLAN

Goal	Planned Intervention – care needed and changes to care	Date & Sign
1) Maintain Safety	• Assess patients physical and mental state in terms of risks of being in hospital - record any risks of: falls, safety, infection, medication issues, tissue viability, wandering, dehydration, nutritional state, depression • Ensure appropriate care plans in place to manage/prevent risks • Ensure at risk patients are highlighted during daily safety briefings • Follow Saving Lives care Bundles to reduce infections - Management of peripheral lines daily recording of visual Infusion; Phlebitis score; removal after 72hrs - Management of urinary catheters daily recording of catheter management - Management of Clostridium Difficile • Record Respiration Rate; Temperature; Blood Pressure; Oxygen Saturations; and Blood Sugars – as per Observation chart. • Report any abnormalities or unexpected signs to medical team – record in the multi-professional clinical record. • Administer prescribed medications and monitor effect - any omissions to medication to be recorded in the clinical record • Ensure that the environment is maintained to reduce risks to patients e.g. patients wandering off ward or those at risk of self harm • MRSA Screen all patients • Results reviewed (date) _____ • Commence 5 day Suppression therapy if indicated (date) • Ensure 3 day break • Re-Screen (date) _____ • Refer to MRSA policy for further action • Liaise with Infection control team. • Reactivate (date) _____ • Ensure VTE risk assessment is completed on Prescription chart **SCI SPECIFIC** • Ensure patient has appropriate call bell mechanism (e.g. light touch) positioned appropriately • High risk of VTE.	

	Action • VTE prophylaxis as agreed with SCIC ☐ • LMWH ☐ TEDS ☐ Pneumatic compression device ☐ VTE prophylaxis to continue for 3 months ☐	
2) Airway & Breathing To maintain airway and safe level of oxygen therapy	• Monitor any shortness of breath, rate & depth of respirations, shallow or abdominal breathing, Asymmetry of the chest • Observe for signs of cyanosis. • Patient requires oxygen therapy ☐ Flow rate_____ Duration_____ • Oxygen via nasal specs ☐ Face mask ☐ Trachy mask ☐ Humidified ☐ • Sputum specimen needed ☐ Sent (date) _____	
	SCI SPECIFIC • Paradoxical breathing in cervical injuries • The development of respiratory fatigue, i.e. shallow grunting breathing, dropping in SaO2 despite O2 supplements • Initial and serial measurements of vital capacity – a gradual drop in vital capacity is a sign of respiratory deterioration • Signs of aspiration or consolidation • Reduced voice quality • If patient in respiratory distress and has cervical or high thoracic cord injury, lie flat and do NOT sit up to maximise gravity to assist diaphragmatic excursion **Action** • Continuously monitor oxygen saturation levels and check respiratory rate regularly • Maintain Sa02 at 95% or above • If longer term 02 is required, it should be humidified • Monitor blood gases regularly • Monitor the vital capacity • If Forced Vital Capacity is less than 1.5L discuss with medical and therapy team for consideration of non-invasive ventilation • Monitor and record the Cough Peak Flow, if less than 160ml, consider using assisted cough techniques, incentive spirometry & mechanical in-sufflatory/ex-sufflatory (cough assist) device • Consider maintaining head of bed flat, if patient paradoxically breathing, to aid action of diaphragm. • Regular turning to optimise V/Q match (two/three hourly) • Regular physiotherapy is indicated • Chest x-ray as indicated	

	• Elective ventilation may be needed • Tracheal suctioning may be needed (be aware of risk of bradycardia) • Information on weaning is available from RISCI (Appendix 1) **Weaning** Weaning should be undertaken on the ventilator free principle, preserving the ventilator tidal volume. Further advice is available from RISCI	
3) Circulation	**SCI SPECIFIC** (Lesions above T6) Look for: • Hypotension • Bradycardia which may precede cardiac arrest (continuous cardiac monitoring) • Hypertension and possible Autonomic dysreflexia **Note:** Hospital Early Warning Scores will need values adjusted for patients with a lesion above T6 **Action** for hypotension: • Nurse patient supine • Monitor BP • Maintain a systolic BP of 90-l00mmHg and a urinary output of 30mls or above per hour • Administer IV fluids (*Do not over-infuse. This may precipitate cardiac failure and pulmonary oedema)* • In rare instances Inotropes may be necessary to maintain a stable BP • A CVP line may be indicated **Action** for bradycardia: • Continuous ECG monitoring • Establish cardiovascular parameters when to use Atropine HR BP • Caution during actions/procedures which may stimulate an abnormal vasovagal response (bradycardia and in extreme cases cardiac arrest) e.g. suction (See Appendix 2) Cardiovascular instability due to SCI requires Acute Care Team review Autonomic Dysreflexia is a MEDICAL EMERGENCY It can be triggered by noxious stimuli: Urinary retention/blocked catheter, bowel distension, constipation, bowel care, pressure ulcers, etc Look for: • Hypertension • Bradycardia • Pounding headache • Sweating above level of injury	

	• Flushed or blotchy rash above level of injury • Tightness in chest • Cold peripheries • Piloerection below level of lesion • Contraction of bladder and large bowel • Penile erection **Action:** • Tilt bed head up • Remove cause • Sublingual Nifedipine 10 mg bitten or GTN sublingual • DO NOT USE ASPIRIN OR NSAID for analgesia afterwards. Use Paracetamol All patients with SCI at T6 or above should have Nifedipine or GTN spray written on the PRN section on their Drug Chart (See Appendix 3)	
4) Communication / Dignity/Respect To enable patient to communicate effectively	• Orientate patient to the ward environment and facilities • Ensure patient knows where personal belongings are located on bed table, locker etc • Ensure all communication is clear and understandable, sensitive to the patients individual needs and preferences • Give due respect to patient's values, beliefs and needs • Complete "Getting To Know You" Booklet or Hospital Passport with patient/relative • Assess patient's communication needs - ensure appropriate levels of communication • Has the Patient any visual impairment? ☐ • Wears glasses for everyday sight ☐ For reading ☐ • Is the Patient hard of hearing? ☐ Wears hearing aid ☐ Other hearing device ☐ Ensure batteries fitted & renewed, hearing aid switched on • Patient has difficulty with speech - Allow plenty of time to explain and ask patient details - Use closed questions (yes/no answers) - Ask relatives how patient usually communicates - Does patient use sign language to communicate? - Offer pen/paper for communication/Use picture board/iPad - Ensure dentures in place if required Ensure the patient and their family feels involved and empowered in the decisions regarding their care and treatment • Have details involving care been discussed with patient/career. • Ensure changes in care/circumstances have been communicated with patient/carer	

	SCI SPECIFIC **Action:** • Refer to PT for adjustable Mirror and light touch call bell • Refer to OT for specialist equipment (adaptive cutlery, book stand) • Early consideration of speaking valves for ETT/tracheostomy • Refer to Speech & Language therapist for communication aids (iPad, alphabet chart etc) as required ☐ Date _____	
5) Pain Management For pain to be as controlled as possible	Has the patient been in any pain Y ☐ N ☐ Details • Pain chart in place ☐ • Be aware of signs of pain – particularly in patients with difficulty in communication e.g. facial signs, behavioral disturbances, • Help patient position to their comfort level, to reduce pain • Patient needs regular analgesia ☐ PRN analgesia ☐ • Patient controlled administration ☐ • Ensure PCA Observation chart insitu. Completed as per protocol • Ensure Naloxone protocol is followed • Monitor and record effects of prescribed medication • Ensure appropriate Trust analgesia document is complete • Refer to Pain team accordingly ☐ Date _____ • Monitor for signs of nausea and vomiting. • Give anti-emetics as prescribed and monitor effect.	
	SCI Specific Look for: • Symptoms suggestive of neuropathic pain • Be aware of possible nociceptive stimulus below level of injury that patient cannot feel due to sensory loss • Hypertension because pain may trigger autonomic dysreflexia **Action:** • Consider use of neuropathic pain agent such as Pregabalin or Gabapentin • Use appropriate analgesia for nociceptive pain • Monitor for autonomic dysreflexia (Appendix 3)	
6) Nutrition To maintain adequate levels of nutrition and fluid intake	**Risk Assessments** • Undertake assessment of malnutrition risk using MUST tool o MUST care plan is in place ☐ BMI is _____ • Observe dietary intake ☐ Food Chart in place ☐ • Red Tray indicated ☐ Housekeeper aware ☐ • Refer as required to dietician ☐ Date referred _____ • Dietician involved ☐ Special diet required ☐	

- Assess if patient is at risk of aspirating fluids ☐
- Patient has difficulty in swallowing ☐ Patient Nil By Mouth ☐
- Date referred to SALT ☐ SALT guidance in place ☐
- Needs thickened fluids ☐ Pureed food ☐ Soft diet ☐
- Control of Diabetes
- Patient on sliding scale Insulin ☐
- Monitor blood sugars ☐ Indicate Frequency _____
- Give appropriate medication
- Seek advice from diabetic liaison nurse
- Activate advice accordingly

Hydration Needs

- Observe daily fluid intake. ☐ Fluid balance chart in place ☐
- Patient has Intravenous line
    - Administer and record fluids as per prescription
    - Follow Saving Lives guidance on peripheral intravenous cannula care
    - Check venflon site daily for signs of redness, tenderness or swelling; Ensure appropriate dressing intact
    - Document daily VIP score
    - Change Cannula as clinically indicated or every 72 hrs as per Trust guidelines.
    - Change giving set every 72 hrs

Nutritional needs

- Help patient with feeding and nutritional intake
- Patient is independent ☐ Needs assistance ☐ Needs feeding ☐
- Special cutlery/crockery ☐ Needs encouragement ☐
- Maintain patient dignity and respect at mealtimes, by protecting clothing from food spillage
- Offer snacks/supplements if appetite/dietary intake is poor
- Patient needs dietary supplements ☐ Food Chart ☐
- Ensure adequate mouth-care and oral hygiene – for all patients. (See Personal oral hygiene care plan)
- Patient has enteral feeding ☐
    - State tube type _____
    - Check Trust guidelines for specific care needed
    - Ensure Nasogastric Tube insertion & Management policy & Procedures is adhered to
    - Change giving set for feed every 24 hrs
    - Check patency and/or position of tube prior to each feed according to dietician instructions and Trust policy
    - NG position form

	- Follow guidelines for flushing tube and care of tube site - Ensure all equipment for feed is changed as per Trust policies **SCI SPECIFIC** Look for • Observe for abdominal distension and listen for bowel sounds (Paralytic ileus is common in spinal shock) • Dehydration • Increased Gastric Ulcer risk **Action** First 48 hours • Keep Nil by mouth • Insert NG tube and keep on free drainage If Paralytic ileus is suspected • NBM and NG tube insertion • If abdomen distended perform digital rectal exam and decompress • Recommence nutrition when Ileus resolves Hydration • Ensure access to appropriate hydration e.g. – Hydrant system Gastric Ulcer Prophylaxis Commence PPI or Ranitidine 150mg BD	
7) Elimination To regain/ retain normal bladder and bowel control/habit	• Most patients after SCI have altered bladder and bowel function • Assess bladder and bowel function and continence (ASIA chart – see appendix 4) **BLADDER** • Bladder is flaccid in SCI and cauda equine injury; prevent over-distension by inserting a FG16 urethral catheter on free drainage initially • Change catheter every 6 weeks to reduce risk of blockage • If catheter blocks, change catheter rather than 'flushing' to enable continued patency • Do not attempt TWOC without prior discussion with SCIC • Patient has urinary catheter ☐ Date inserted: _____Size_____ details to be recorded on specimen record and clinical record • Patient requires hourly urine measurements ☐ • To appropriately manage the urinary catheter Follow Saving Lives guidance on Urinary Catheter Care and standardised care plan • Patient requires: Leg bag ☐ Night bag ☐ Bed hanger ☐ • Flip flow use commenced ☐ Date _____ • Use Flip flow guidelines ☐ (Appendix 5)	

	Without catheter: • Post-void bladder scan to measure residual volume • Continue with bladder scans for 72 hours • Document frequency and volumes • Regular help/encouragement with fluids • Long-term catheter should be inserted before discharge • Referral to District nurse for ongoing catheter care on discharge if appropriate • Refer to tissue viability protocol for skin care management • Urinalysis indicated by clinical symptoms and signs • Send MSU if signs of infection Date MSU sent _____ • Maintain privacy and dignity at all times • Assist with urinary continence through regular toileting, increase mobility, encourage fluid intake. • Patient needs pads during the day ☐ Night ☐ Convene ☐ • Refer to Continence Advisory Team ☐ . **BOWELS** • Use South West Neurosciences bowel protocol (Appendix 6) • Determine level of SCI for specific bowel management: • T12 and above SCI - Reflex bowel • Ensure Glycerin suppositories are prescribed daily • L1 and below – Areflexic bowel • Stool chart in place and record if continent or incontinent • Patient has Colostomy ☐ specific care plan in place ☐ • Encourage fluids and fibre diet • Risk of paralytic ileus	
8) Personal Hygiene For hygiene needs/choices to be met	• Discuss need/choice for daily/regular hygiene • Promote as much independence and choice as possible try to reflect arrangements at home/community • Assist with wash/ bath/shower as required: Patient needs: • Full bed-bath ☐ Assisted wash ☐ Help with bath/shower ☐ • Bowl provided ☐ Walk to bathroom ☐ Minimal assistance ☐ • Independent at bedside ☐ • Ensure all intimate areas of the body are checked and clean: • Eyes, ears, nose, nails, hair, umbilicus, genital areas & feet • Offer facilities/advice for oral hygiene as required. • Follow oral hygiene care plan A: ☐ B: ☐ C: ☐ D: ☐ • Give basic foot care as needed; trim/file/clean toe nails if completed Basic	

	Foot care training. • Maintain privacy and dignity at all times during personal care • Referral to OT for assessment/therapy to improve functional activity ref independence with personal hygiene? ☐ Date _____ **SCI SPECIFIC** • If wearing a collar- refer to collar information leaflet 'You and your collar'. Liaise with nurse/physio competent in collar care Complete Collar information sheet ☐ • Increased risk of developing pressure areas due clothing and lack of sensation- Patient should not wear clothing in bed • Patients should not be nursed on/ in incontinence pads. • Sanitary towels can be used without underwear	
9) Tissue Viability To prevent pressure ulcers	• Complete risk assessment (Waterlow) within 4 hours of admission to ward area and then minimum of daily • Complete skin assessment within 4 hours of admission to ward and then minimum daily (use EPUAP) • Patient requires the following to protect pressure areas: Dynamic (air) mattress ☐ Cushion ☐ Heel protectors or offloading ☐ Other ☐ ……specify • Monitor all pressure areas on each shift and record any deterioration/damage – All grades to be recorded on Datix as clinical incident. Refer to tissue viability • Regular re-position of patient; Re-positioning chart in place ☐ • Ensure skin is moisturised – fluid intake encouraged, emollients needed to dry skin ☐ barrier cream needed ☐ • Ensure patient is positioned appropriately in bed or chair – use pillows to support limbs positions	
	SCI SPECIFIC: Nurse naked in bed When sitting out: Ensure patient in seamless clothing as seam and wrinkling of clothing can cause pressure areas Consider stability of patient's spinal condition and presence of pressure ulcers when selecting mattress – if unsure use high specification foam mattress and seek advice. Patients should initially be turned two - three hourly, skin should be checked on each turn Avoid use of resting and foot drop splints and use pillows to block feet Use passive stretches and pillows for positioning upper limbs See Appendix 7	

10) Wound Care To promote wound healing	Patient has wound ☐ Wound care plan commenced (including body diagram/wound diagram/measurements recorded) ☐ Refer complex wounds to Tissue Viability for advice ☐ Date _____ Assess for pain and discomfort prior to and during procedure and address Observe & report to medical team, any signs of infection or deterioration of wound such as infection, inflammation, swelling or exudate Record frequency of wound checks required	
11) Mobility To promote maximum level of mobility and safety	• Patient handling assessment completed/updated • Patient being LOGROLLED ☐ (Appendix 8) • Assess risks of falls; discuss risks with patient and family – MORSE risk assessment completed/updated ☐ • Assess dependency score as per document • Risk Assess patient for appropriate use of bed rails in bed; • Bed rails appropriate ☐ Bumpers needed ☐ Documentation completed ☐	
	SCI SPECIFIC • Discuss with patient and family regarding importance of regular positioning changes when in bed- Skin care, Comfort • For patients with paralysed limbs, undertake passive movement exercises of limbs to improve circulation and muscle tone and prevent stiffness and contractures • Patient needs assessment and advice regarding specialist rehabilitation Refer to Physio ☐ Date referred _____ • Ensure walking aids are used/available to patient – as per Patient Handling Care plan • Record patient progress with mobility and safety • Recumbent Rehabilitation as discussed with SCIC (Appendix 9) **Gradual mobilization plan/Sitting out of bed** (Appendix 10) PRIOR TO SITTING PATIENT OUT OF BED (C1- L3 SCI) • Discuss the process and likely experience of getting out of bed e.g. Dizziness/BP drop. Reassure the patient • Ensure collar securely fitting (if applicable) **a) Blood pressure management** • Long leg TEDs • Abdominal binder (If C1- T12)- liaise with physio/orthotics • Consider medication - Ephedrine for T6 and above (cautious use as arrhythmogenic), if BP control a problematic- liaise with doctor • Monitor for hypotension, fatigue and nausea • Gradual acclimatisation to being upright in bed before sitting out (tolerating at least 2 hours) Sit up in bed 15 degrees ☐ 30 deg ☐	

	60 deg ☐ 80 deg ☐ Ensure patient in side-lying when not doing sitting acclimatisation. **b) Clothing** • Ensure patient in seamless clothing as seam and wrinkling of clothing can cause pressure damage **c) Seating** • Refer to PT/OT for seating assessment • Ensure appropriate seating for patient- Tilt in space wheelchair (Action 4/ Rea Azalea). • Ensure appropriate pressure relief cushion for patient • Ensure postural alignment ☐ Adjust footrests/armrests • Teach basic wheelchair skills- Use of brakes, footplates **d) Pressure area management when sitting out of bed** • Teach Pressure relief techniques when sat out • Check at risk pressure areas when returning to bed • If any redness persists over 1 hour, discuss with MDT at whiteboard meeting • Concerns regarding persistent red at risk areas- Refer to tissue viability ☐ Discuss with ward therapy team ☐ Place patient on appropriate bed-rest regime ☐	
12) Emotional and mental well-being For the patient to feel supported and reassured	• Help the patient to feel settled and supported, allow time for him/her to express their feelings and fears • Talk and listen to the patient – identify any fears, concerns or worries; allow the patient time and privacy to express their feelings. • Are there concerns about the patient's mental well-being: • Low mood ☐ Confusion ☐ Memory loss ☐ • Patient referred to psychiatric liaison team for assessment and advice on care plan ☐ Date_____ Date seen _____ • Give clear explanations of all events / procedures • Allow time for patient to express anxieties and ask questions • Does the patient have emotional/spiritual concerns? Yes ☐ No ☐ • Offer support from Department of Pastoral & Spiritual Care: Date of referral _____ Date seen Consider referral to other support /voluntary agencies.	
	SCI SPECIFIC • Refer to Health Psychology if patient requires professional support • Provide patient and family with information on the Spinal Injury Association www.spinal.co.uk / 08456786633 • With patient: Discuss referring to Spinal Injury Association Peer Support Officer ☐ Refer if patient gives consent- to the South West | Spinal Injuries Association Tel: 01908604191 sia@spinal.co.uk	

13) Sleep To promote adequate rest and sleep	• Encourage patient to rest for short periods during the day; • Encourage the patient to keep to usual sleep/bedtime behaviour and routines as far as possible; • Observe and record nature of sleep whilst in hospital • Consider clinical or medication reasons which would disturb/help sleep • Ensure pain relief given, patient is comfortable, • Patient needs/prescribed night sedation – observe effects • Record any episodes of increased confusion at night – refer to medical team for review • If established on NIV- involve Home Ventilation Team 07884324389/ 07827081778 **SCI SPECIFIC** • Monitor for signs and symptoms of obstructive sleep apnoea (All SCI patients) • Respiratory referral if suggestive of OSA	
14) Management of the Collar	• If patient in Transit collar- Competent person to measure patient for a long term cervical collar within 24 hours ☐ Date:____Time:_____ • Advise patient on need for collar care and reason for collar • Provide with Collar care Booklet (Appendix11) • Ensure patient has secure head-hold for collar change • Change collar pads daily • Hand wash collar pads, leave to air dry • Ensure collar is fitting snugly after collar care completed- no more than 2 fingers behind the back of the patients' ear. • Personal care of patients neck to be completed when collar pads changed- ideally shave unless full beard • Check for pressure areas daily during collar pad change or if patient complains of discomfort. Liaise with tissue viability if concerned and check collar fit. • Discuss with collar competent therapist or nurse if any concerns with fit. It is usual practice for patients to have two Collars and pads for the purpose of hygiene.	
15) Management of the confused patient To reduce short-term confusional state and ensure patient safety is promoted	• Consider history of confusion and impact on functional abilities - remember Delirium and Depression must be treated promptly • Identify patient risks of confusion – infection, electrolyte imbalance, hypoxia, dehydration, poor nutrition, medication, pain, sensory loss, constipation, lack of sleep, alcohol withdrawal • Treat/address/minimise above risks/causes of confusion • Assess patient's orientation and memory on daily basis – record any deterioration of cognitive function in clinical record	

	• Consider use of Abbey Pain scale for those with Dementia, to assess pain status and response to analgesia • Any deterioration in cognitive function to be reviewed by the clinical team – review medication, infection status, physiological status • Monitor patterns of behaviour to establish any routines helpful to the patient • Record patient biography/social history in Getting To Know you leaflet – to identify cues with which to help orientate eg family names, pets • Assess risks of environment - including reduction of clutter and noise, avoid multiple bed moves. • Ensure non-confrontational approach and avoid disputes • Orientate the patient in time, place, person throughout the day • Discourage sleep during the day – as this can lead to increased activity/confusion at night • Use appropriate care plan for management of specific confusion using Restraining Therapies policy risk assessment and care plan Where patients lack capacity to make decisions for their care or treatment, such decisions cannot be made with patient consent. The Mental Capacity act requires such decisions to be made in the patient's Best Interest. Where patients lack mental capacity and are un-befriended and Best Interest decision is needed, referral must be made to the Independent Mental Capacity Advocate (IMCA) service	
16) Management of patients at High Risk of Falls To promote the safe management of patient's at high risks of falls	• Complete Falls Risk assessment and care plan ☐ Update every 3 days/if the patient's condition changes or after a Fall. ☐ • Those with High Risks of Falls –implement Falls Care plan: o Ensure medication review o Position patient in higher observation bed where possible o Consider need to increase staff to ensure higher level of supervision – record risk assessment where staff not available • Discuss high risks of falls with patient and family– give information leaflet outlying care for falls risk management • Consider use of Low profile bed to reduce falls from bed • Assess patient for appropriate use of bed rails in bed; Bed rails appropriate ☐ Bumpers needed ☐ • Ensure regular observation/monitoring of patient risk of falls - patient requires Intentional Care • Identify falls risks of confused patients and discuss with family/team • Record any falls as per Incident reporting policy – ensure regular observations of patient condition; review Falls Risk assessment; ensure medical review; alert to patient fall in clinical record. • Discuss any incidents of falls with the family • Escalate patients with repeated falls to Matron and medical team	

	• Any form of restraint on the basis of patient safety must have risk assessment in accordance with the Trust policy on the Use of Restraining Therapies in an acute hospital setting • Any restriction of patient liberty must be undertaken within the framework of the Mental Capacity Act and Deprivation of Liberties safeguards. Any prolonged Deprivation of Liberty must be authorised through Deprivation of Liberty Safeguard office. **SCI SPECIFIC** SCI patients are at risk of falls when seated due to neurological impairment therefore use seat-belts when sat out. Use Tilt in space chairs as appropriate following Neuro Assessment	
17) Communication of care and treatment plans and discharge planning To ensure accurate and timely information about care, treatment and onward care needs – to patient, family and onward care staff/services	• Plans for discharge from hospital and onward care need to be commenced on admission • Those requiring complex discharge arrangements must be referred to the relevant Discharge team(s) ☐ and Single Assessment Process ☐ • Ensure the patient and their family are involved and empowered with relevant information and discussions • Record conversations with family members in the clinical record • Ensure accurate and timely assessment of patients ongoing needs by multi-professional/multi-agency team • Where patient lacks Mental Capacity to make care/treatment decisions and are un-befriended, refer to Independent Mental Capacity Advocate service for involvement in Best Interest decisions • Ensure accurate and detailed information to Community nursing team, Care Homes or other care settings are given in writing – complete Patient Needs on Transfer documentation, keep copy in clinical record • Complete day of discharge checklist **SCI SPECIFC** Ensure referral to SCI Centre is completed as per pathway Complete Rehabilitation Prescription if appropriate	

[Please see Separate document for all appendix's]