**NMTRG Guidelines for the assessment and rehabilitation of the Major Trauma patient**

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| **Discipline: Physiotherapy** |
| **Guideline 1: Management of bladder and bowel** |
| The PT should have knowledge of internal abdominal content and the following;   * Anatomy of the abdomen * Incision implications * Oxygenation delivery * Respiratory assessment and chest management * Drain management and awareness * Mechanisms - Blast / penetrating / blunt trauma mechanisms – the implications on chest management * Awareness of medical management – Difference between ileostomy / colostomy, high output stomas, leaking, medicine adjustments |
| The PT should be able to recognise;   * Respiratory deterioration – oxygen management * Chest management (auscultation/oxygen delivery management/pain) – prevention. Additional respiratory devices e.g cough assist, IPPV, IS, PEP * Pain control management * Signs of compartment syndrome * The escalation compartment syndrome concerns * Management of post-op compartment syndrome (fasciotomies) * Risks associated with caring for patients with drips and drains * Risks associated with caring for patients with stomas * Muscle wasting implications on rehabilitation – prevention e.g PRAFOS, positioning. |
| The PT should be able to offer the following interventions   * Respiratory assessment – management * Pain control * Positioning / ROM / mobility maintenance. * Post-op general observations (circulation, sensation and movement) * Assessment for peripheral nerve injury if identified * Functional Upper limb assessment / Lower limb assessment / mobility assessment * Oedema advice and management – positioning management / orthoses * Knowledge and provision of equipment to improve function – e.g. r/zf * Assessment of equipment needs – walking aids, seating, chair. * Assessment of transfers / mobility * Home visit where appropriate if required. * Location of stoma and impact on function / transfer ability / maintaining hygiene * Encouragement to engage with stoma, reassurance, education. * Appropriate assessment space, private space to address concerns * Quality of life and grading tasks important to patient * Involve family in care / rehab - goal setting. |
| The PT is expected to complete this assessment and intervention;   * Early in the patients admission – within 24 hours of admission * As part of a 7 day service inclusive where appropriate – respiratory assessment / mobilisation |
| The PT should have knowledge of additional services including;   * On-going rehabilitation progression services * On-going funding streams if required * Repatriation pathways * Citizens advice * Psychology input as inpatient and after discharge * On-going services * Age UK / Live Well At Home / IAPT * Local and network services |
| The PT understands how to access the following pathways   * Onward outpatient therapy input * Rehabilitation services * Splint / Bracing clinic * Falls prevention * Help at home on discharge * TPN provision at home * Community therapy / on-going referrals. |
| If required the patient has access to;   * Rapid access rehabilitation * Vocational rehabilitation * Instant community rehabilitation * Follow up in an MDT clinic * Access to a dementia pathway * Complex MSK rehabilitation * Educational intervention * Timely access to Mental health / IAPT services * Regular input to prevent deconditioning (particularly with TPN) * If identified for Intermediate Care, continue regular review (weekly minimum) to recognise if progress made and prevent loss of function and review if remains appropriate pathway. * D2A for stoma management if required at home * Referral to continence service if concerns re: leaks overnight, Womens/ Mens health PT services if available |
| Consideration for long term rehabilitation   * Links with preventative teams * Patient support groups / group rehabilitation |
| Links  Sheffield Health and social care Iaptsheffield.shsc.nhs.uk  William Merrit driving assessment centre [www.wmdlc.org](http://www.wmdlc.org) |
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