**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
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| 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.
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| 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.
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| 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
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| 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
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| 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.
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| 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
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| Consideration for long term rehabilitation* Links with preventative teams
* Patient support groups / group rehabilitation
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| LinksSheffield Health and social care Iaptsheffield.shsc.nhs.ukWilliam Merrit driving assessment centre [www.wmdlc.org](http://www.wmdlc.org) |
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