Burns Rehabilitation Prescription Guidance Document 2022/23

February 2022

Overview

In April 2022 the new Rehabilitation Prescription will be launched and the completion of this will be measured on the revised Burns Quality Dashboard.

The rehabilitation prescription describes the patient's physical, cognitive and psychosocial needs, considered in the context of their pre-injury life and states how these will be addressed after discharge. Having these in a single document is incredibly helpful for the patient, their family and also for their GP.

The prescription is an extension of a discharge/transfer summary and should also include ongoing health and social care plans so that everyone is working from one document, which is regularly reviewed and updated.

A first rehabilitation assessment should take place within 48-72 hours of the patient's admission and the Rehabilitation Prescription will have to be completed for all resuscitation burn patients (15% TBSA adult/10% TBSA Children) who need rehabilitation at discharge. If the patient is found to have no rehabilitation needs, the full rehabilitation prescription does not need to be completed.

How should it be completed?

1. The Rehabilitation Prescription must be developed with the involvement of the patient and/or their family/carers

2. Administered by all relevant members of the MDT. But you might want to allocate a dedicated lead per service.

3. The Rehabilitation Plan must be discussed with the patient, where possible, and copies provided for them, their General Practitioner and the next care provider

4. Rehabilitation Prescription- should be completed by Health Care Professionals after a multidisciplinary team (MDT) assessment and signed off by senior staff members

Personal Information
This can be transcribed by any member of the team, including data clerks etc but may need nursing involvement to complete safeguarding issues

Burn History
This could be completed by medical or nursing staff

Respiratory/Intensive Care
This will only be applicable to patients who have spent time in intensive care. This can be completed by any member of the MDT.

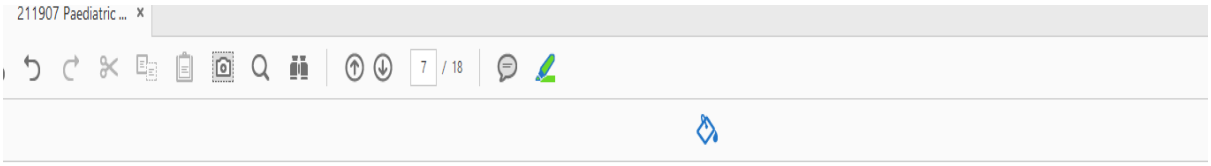
Communication/Cognitive Impairment
This may not be applicable to all patients, but those who have cognition and communication difficulties. This can be completed by a Speech and Language Therapist, nursing team or other appropriate member of the MDT.

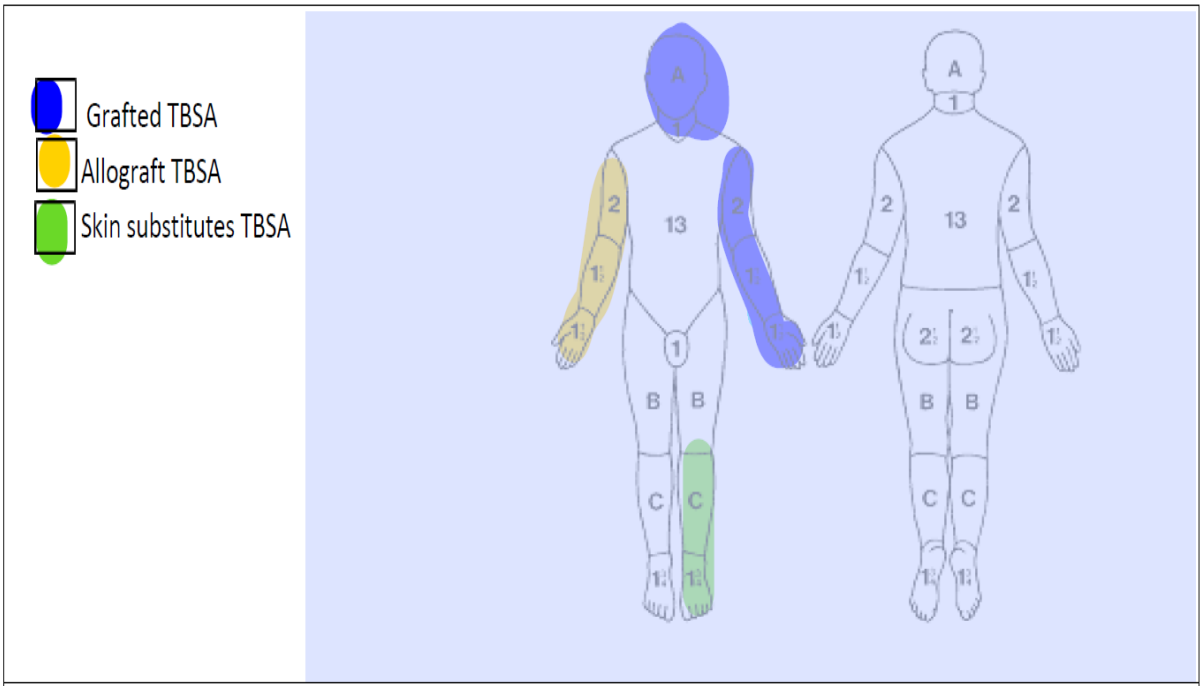
Nutrition and Hydration
This will probably be applicable to most people and would most likely be completed by the dietitian, although nursing staff should be able to complete some components.

Speech and Language Therapy
This will not be applicable to all patients but those who continue to have ongoing swallowing and speech difficulties. This should be completed by a Speech & Language Therapist.

Continence
This would be completed by nursing staff, they would need to identify any changes to normal continence and whether patient requires any stool management

Skin/Burn Wound
This would generally be completed by nursing staff.
To amend the colours ensure that the colour picker is on the toolbar. In **Adobe Acrobat Reader** go into tools which is at the top left corner. Click on comment and this should add the colour picker to the comment bar at the top of the page. Choose a colour to use with the highlighter to draw the area required e.g. grafts, burns etc. Mark the corresponding box with the same colour, this can be returned to as often as required. This may be completed just prior to discharge.



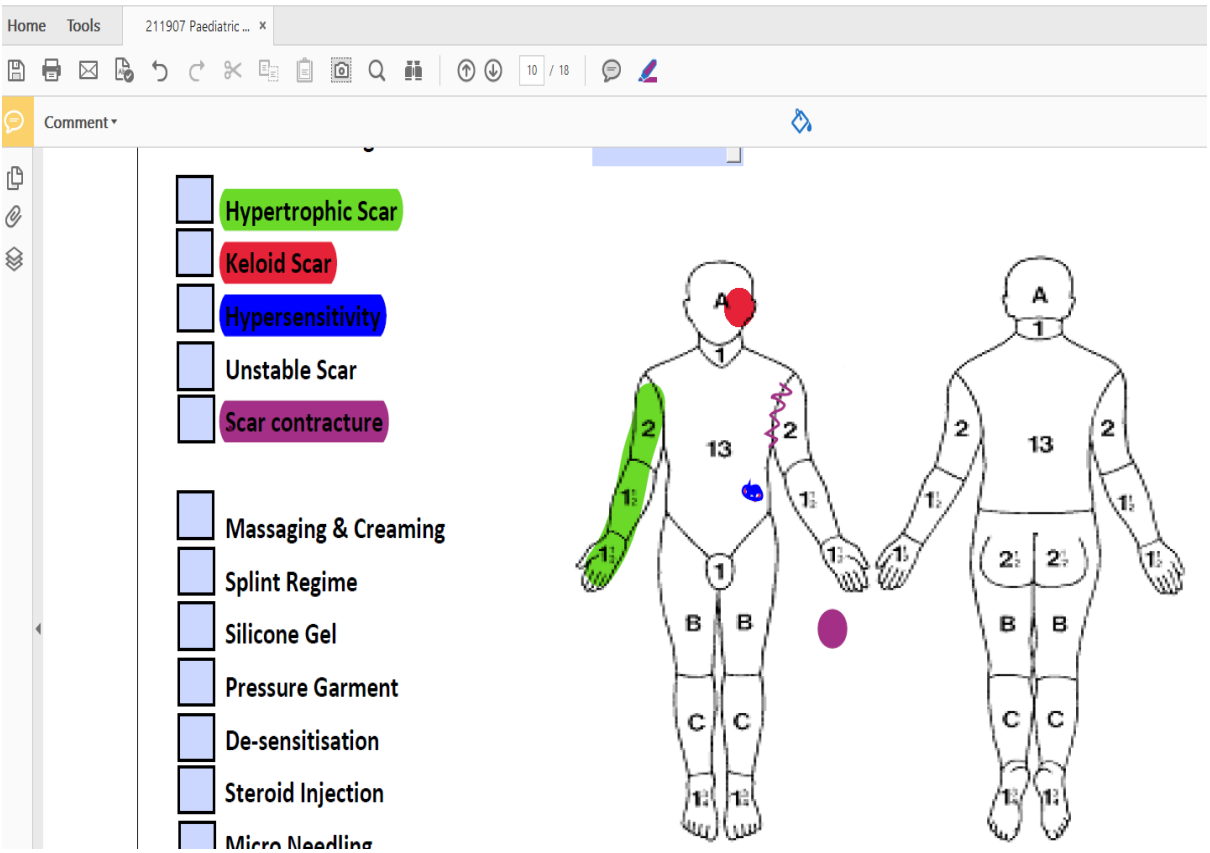


Assessment of Rehabilitation Needs

Skin
Wounds should be categorised by the tissue present. This enables progression of the wound to be documented objectively. Any pressure ulcers that have developed during admission should be documented. The latest wound microbiology should also be documented. This would be documented by nursing staff.

Therapy

These have been left as free text boxes so as much detail as possible may be included.
To highlight or draw where the scars are you need the colour picker. In **Adobe Acrobat Reader** go into tools which is at the top left corner. Click on comment and this should add the colour picker to the comment bar at the top of the page. Here a colour can be chosen to use with the highlighter to draw the area required e.g. grafts, burns etc. Mark the corresponding box with the same colour. For finer detail or smaller areas then on the top right go into tools and search for pen, it will bring up draw, click on this and then go back to the document. The highlighter will then work like a fine pen and utilise the colour picker to change colours.



Neuropathic pain and itch should be recorded in this section, if these are issues. This can be completed by a therapist or other appropriate member of the MDT.

Psychological/Mental Health Issues
This allows the pre-injury issues to be documented as well as any ongoing concerns and interventions required. This would ideally be completed by a psychologist or mental-health liaison.

Discharge Planning
Preparing the patient for discharge is essential for social reintegration. This section allows documentation of school or work reintegration and also where the patient is going to for their ongoing rehabilitation. Even if you are unable to meet their requirements, please document this as this will help to build a case for burn rehabilitation facilities. This can be completed by any appropriate member of the MDT.

Transfer/Discharge Planning
This section gives the details of where the patient is being transferred to, any follow up details, and information given to the patient. This can be completed by any member of the MDT.

Professionals Involved
This allows the contact details of the team who have been caring for the patient to be transferred with the patient, so should there be any queries the receiving team can contact the relevant professional. Each member of the MDT should complete their own details.

This is the first iteration of the Rehabilitation Prescription, and it is certain that it will need amending. Wider feedback will be sought towards the end of the first 12 months, which will form the basis of any amendments.

Frequently Asked Questions (FAQ's)

Q: Is the Rehabilitation Prescription completed at each point of transfer of the patient throughout their rehabilitation journey? (i.e. from Burn Centre to Burn Unit to Specialist rehabilitation and Community settings)

Yes – the intention is that the Rehabilitation Prescription continues to be updated and used beyond the Burn service in all rehabilitative, outpatient and community settings.

Q: What detail is required within the RP following the "first assessment within 48-72 hours"?

The initial RP should contain the relevant detail pertaining to patient demographics, mechanism of injury, a list of relevant injuries and a management list for each of these injuries.
It is accepted that the RP will evolve over time with a definitive version encompassing a Rehabilitation Plan being finalised at the point of transfer of care or discharge from the Burns Service.

Q: Should a copy of the RP be sent to the GP if a patient is sent to Specialist rehabilitation directly from the Burn Service?

Yes – a copy of the RP should be sent to the GP and the next care provider on transfer or discharge from the Burn Service. It is accepted that this document will continue to evolve over time. The next care provider has a responsibility to ensure that the RP continues to be updated whilst the patient remains under their care and a further copy of the RP should be sent to the GP & next care provider on discharge

Q: What are the likely actions for GPs that the RP will identify?

It is anticipated that the actions likely to be highlighted to GPs may include requests to review medications (including opioids), arrange onward referrals for Specialist services (i.e. Counselling or Psychology), wound and dressing checks by community nurses, etc

Q: What is deemed the appropriate "discharge" point when the RP should be completed?

It is recommended that the RP is completed / finalised at the actual point of discharge or transfer of care from the Burn Service.

It is accepted that there may be a delay in patients repatriating to their local hospitals or accessing the appropriate Specialist inpatient rehabilitation beds, and hence local teams may decide that they wish to complete the RP when the patient could be discharged rather than at the point of actual discharge. However, the rehabilitation needs of patients may continue to change prior to their actual point of discharge whilst they are waiting to access appropriate services or units. The RP will require updating at the point of transfer / discharge to reflect this.

Q: How should the Rehabilitation Prescription requirements be managed if the patient chooses to take self-discharge from the Burn Service?

In this situation, it is recommended that a copy of the Rehabilitation Prescription is sent to the GP and next care provider as appropriate. It may not be indicated for a copy of the Rehabilitation Prescription to be sent to the patient if there has not been the opportunity to discuss the document with them. It would be appropriate to indicate that it was "not appropriate" to give a copy to the patient.

Q: Are patients from Overseas who receive acute care and management within a Burn Service, eligible for a RP?

A patient from Overseas treated in a Burn Service with identified rehabilitation needs should receive a copy of their RP on transfer or discharge from the Burn Service. This will help to inform ongoing rehabilitation needs / provision for the next care provider whether this be in the patient's home country or within the UK. An appropriate category in relation to Discharge destination should be selected

Q: If the patient has no ongoing rehabilitation needs at the point of discharge / transfer of care, do they require a RP?

If a patient has no ongoing rehabilitation needs at the point of discharge or transfer of care, they do not require completion of the RP and it is not necessary to complete all of the mandated fields (i.e. Copy to patient / next care provider / GP, etc.).

Q: What is the patient's rehabilitation need? – In relation to this category, how should we indicate where patients require multiple services to meet their rehabilitation needs (i.e. Outpatient support and community therapy)?

In this instance, it would be advised that you indicate the main service provider that will provide and meet the rehabilitation needs of the individual on discharge.

Q: What is the patient's rehabilitation need? – How do you record when a patient is discharged directly to a Mental Health unit?

In this instance, it would be appropriate to indicate that the patient has been discharged / transferred to a "Specialist Non-Burn Inpatient" setting.

Q: How can the RP be saved and be accessible to all staff?

Ideally this would be electronically online but that is not available currently. This will depend on each service, but some are housing the document on a shared folder that all the MDT can access and save the document with a new date each time it is updated. However, this will depend on each services governance arrangements, so some are printing the document out each time it is updated

Q: Who is responsible for completing the RP?

This is an MDT document so everyone is responsible, but many services are identifying a lead who can ensure the overall document is completed

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On behalf of the National Burns ODN Group
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