Tabled by Dr Adelie Hodgkinson 20.6.08

Case 1

55 year old lady, pedestrian hit by truck 04/03/2008

Multi trauma – cerebral frontal contusions, #ribs, bilateral hip #, #pelvis, sacrum, depressed orbital, # TMJ bilateral, #C6 transverse process, Skull # into foramen magnum, subluxation C6/C5, left # ankle and fibula.
Head injury – GCS 14 at scene and on admission to hospital, cerebral frontal contusions, skull fracture and PTA 8 days.

Rehabilitation commenced in acute hospital, after CTP claim accepted transferred to a private rehab hospital on the 19/05/2008.
Function at that stage; references to cognition or mental state in notes mention her lack of confidence, depressed mood and anxious state, intermittent dizziness, short term memory problems, difficulty understanding documents.
Walking with assistance of 1 and crutches.

Now discharged home from rehabilitation and referred to Brain Injury Rehabilitation unit.

Issues: Functional independence measure.

1. FIM timing.
FIM not performed in acute hospital but descriptively would have reached criteria for LTCS scheme. An application early in her stay would have probably resulted in her acceptance at least as an interim participant into the scheme.
However if now independent is this person eligible for LTCS scheme?
Timing of the FIM assessment tends to be at around the time of the application for to LTCS and is highly variable.

2. Scope of the scheme.
Is it the intention of the scheme to include this type of person? It is likely that this person will not require lifetime support but required and will require further months of rehabilitation.

3. Awareness of LTCS.
Clearly this was not considered in the acute or rehabilitation phases. More education is required particularly in orthopaedic wards.

4. CTP claim.
Fortunately this lady was covered by a CTP claim but many similar cases are not or liability decisions are delayed for a considerable time.

Case 2

46 year old married woman, mother of 2 children, the driver involved in an accident 22/02/2008.

Ejected from the vehicle, GCS 3 at scene and on admission. Multi trauma; Multiple cerebral contusions, # C1 and T6 spine, Left brachial plexus injury, facial #, splenic laceration.
PTA 29 days. Entered into LTCS scheme while in the acute hospital prior to referral for rehabilitation.
A CTP insurer was involved early for the children and husband and further confusion arose with different messages being given by that insurer and other friends wishing to help.
The discharge plan involved multiple therapists and a care agency. This revealed the complexities of the planning process in the paperwork and approval process required. Considerable time was spent by staff in completing the forms and meeting the documentation requirements.

Issues:

1. Communication.

In the early stages there was considerable liaison between the LTCS coordinator and the patient's husband. This filled a need both for emotional and practical support but on arrival in the Brain Injury unit the husband had difficulty transferring to the rehabilitation team. He preferred to continue to liaise directly with the LTCS coordinator, often not communicating important issues to the rehabilitation team. This led to mixed messages regarding rehabilitation plans and the discharge process became more complicated than needed.
Once this was identified as a problem, additional communication and emphasis with the husband of the roles of each of the staff largely resolved this problem.
Establishing regular communication with the LTCS Coordinator and if confusion of roles is identified early rather than after it has caused problems will avoid disruption to the rehabilitation process.

2. CTP claims in addition to LTCS.

In general this has been a relatively smooth interaction but participants and family members have often become confused between the schemes and what can be offered by one scheme but not the other.

3. Paperwork.

The forms for the LTCS are lengthy, frequently duplicate information and add to the non clinical time of the therapy staff. The number of patients now covered by the scheme is approximately 50% of admissions, (~double that of the number previously covered by CTP). While revenue has increased the process by which this increased revenue can be used by the brain injury units to supplement staff time is lengthy and inconsistent across AHSs. It would assist the Brain Injury Rehabilitation Units if the Department of Health could be encouraged to ensure that the Brain Injury Unit's revenue be used to employ adequate numbers of staff. There is currently no obligation by the Area Health Services to use the revenue in this way.