REHABILITATION MILESTONES CHECKLIST
PHASE 1 (Admission - Mobilisation)

Milestone	Responsible	Completed
Discharge date set on date of admission (based on LOS model)	Consultant DisCo	
Long Term Patient Plan completed at team meeting/first case conference	All	
Start Patient Education Plan (PEP) including Patient Education Programme (if bed can be moved)	All	
Diagnosis discussed with patient and family	Consultant	
GP informed of admission by letter	Consultant	
Allocation of named staff to meet with patient	All	
Daily medical review, including appropriate reviews, assessments and referrals.	Medical Team	
Assess and monitor neurology	Consultant SHO, PT & OT	
Acute bladder management plan formulated, (more in Medical Admission Pathway)	Medical Team	
Nursing assessments and Nursing Management Plan commenced	Nurse	
Physio assessment (including resp) and treatment plan completed	PT	
OT assessment and profile Including housing situation completed	OT	
Referral to Community OT with request for access visit	OT	
Hand management plan formulated	OT	
Preparation for mobilisation, (profiling, tilt table, 30˚ bed tilt foot down)	PT	
Pressure clinic assessment – for cushion recommendation	Pressure Clinic staff	
Recommendation and referral for orthoses	Consultant & PT	
Muscle chart completed	PT	
CCG and Social Services (if needed) notified of admission	DisCo	
Patient to see DWP (if requested)	DisCo	
Respiratory Patients Only		
Relevant protocol to be activated for ventilator dependent patient	Consultant	
Follow Spinal weaning protocol	Resp Team	
SALT referral	Resp Team	

PHASE 2 (Mobilisation – Up4 hrs a day)

Ongoing PEP, including Patient Education programme	All	
Weekly medical review, including appropriate reviews, assessments and referrals.	Medical Team	
Weekly review of nursing care plan	Nurse	
VUD's and long term bladder management plan formulated	Medical Team	
Prognosis meeting with patient and family at 12 weeks post admission	Medical Team	
Increase skin tolerance in bed and wheelchair, including mattress assessment	Nurse & PT/OT	
First time on plinth (when up for 4 hours)	PT	
Baseline assessments (including spasticity and functional)	PT &OT	
Monitor neurology	OT & PT	
Pressure clinic appointments (1st on mobilisation, 2nd 2 weeks later)	Pressure Clinic Staff	
Contact made with wheelchair services	OT/PT	
Teach basic wheelchair skills, including posture	OT/PT	
Home visit completed by Community OT (if appropriate)	OT	
Identify discharge destination	DisCo	
Housing application and Housing Needs Report compiled (if needed)	DisCo	
1st Goal Planning Assessment completed	DisCo/OT/ PT	
Liaise with relevant community staff for safe discharge planning	DisCo	
Respiratory Patients Only		
Carer/family resp training started	Resp Team	
Follow relevant ventilator/weaning protocols	Resp Team	

PHASE 3 (Up 4 Hrs a day – 2 weeks prior to discharge)

Ongoing PEP, and Patient Education Programme	All	
Consider cognitive assessment if appropriate	All	
Patient to start directing own care and increase independence	All	
Weekly medical review, including appropriate reviews, assessments and referrals.	Medical Team	
Identify care needs and complete CHC needs assessment (if needed)	All	
Send CHC application to relevant CCG and liaise with them re discharge planning	DisCo	
Complete relevant carer training/supervise carers	All	
Liaise with District Nurses re ongoing care needs and delivery of relevant equipment	Nurse	
Complete bowel care over toilet training (as appropriate)	Nurse	
Posture assessment completed, identify wheelchair specification and cushion	PT/OT	
Liaise with wheelchair services for provision of interim wheelchair, pressure relieving cushion and long term chair	PT/OT/PC	
Interim wheelchair and cushion received		
Ongoing wheelchair skills, basic and advanced	PT/OT	
Attend hydrotherapy (if appropriate)	PT	
Trip out of unit and explore leisure activities	PT/OT	
Monitor neurology and record	PT/OT	
Ongoing relevant assessments (spasticity, environmental controls)	PT/OT	
Trial Toto turner or independent turning at night	OT/Nurses	
Trial and order relevant specialist equipment	PT/OT	
Provide information/advice on driving/employment	OT	
Provide information of support agencies/charities	All	
ADL flat stay and weekend leave (if possible)	OT	
Home visit (if needed)	OT	
Liaise with relevant community staff for discharge planning	DisCo	
2nd GPA completed	DisCo	
Evaluate all goals at final GPM	All	
Respiratory Patients Only		
Respiratory equipment agreed and purchased with CCG agreement, and in use, with service contracts in place for discharge	Resp Team/ Resource Co-Or	
Establish consumable ordering process and funding with CCG	Resp Team	
Ongoing carer/family resp training	Resp Team	
Follow relevant ventilator/weaning protocols	Resp Team	

PHASE 4 (2 weeks up to discharge date)

Complete PEP and Patient Education Programme signed off	All	
Patient to direct own care and achieve self sustaining levels of function	All	
Complete remaining relevant carer training/supervise carers	All	
Weekly medical review, including neurology review and final bloods	Medical Team	
Review medication and prescribe TTO's	Consultant	
Ensure medications and consumables ready for discharge	Nurse	
Complete medical discharge summary and letter to GP	Consultant	
Send letter to District Nurse, copy to DisCo & Community Liaison Team	Nurse	
Complete Discharge Checklist	Nurse	
Discharge appointment with pressure clinic and meet community liaison staff	Nurse	
Monitor neurology	PT/OT	
Liaise with community staff to ensure equipment and follow up in situ (if needed)	OT	
Complete transfer and discharge summaries	PT/OT	
Ensure Safe Discharge Criteria fulfilled	D/c co-ord	
Complete electronic discharge summary and receive TTO's on ward (Nurse to complete final sign off)	All	
Respiratory Patients Only		
Write to local services (ambulance, utilities etc) to formulate emergency plans for community	Resp Team	
Follow relevant ventilator/weaning protocols	Resp Team	
Complete family/carer resp training	Resp Team	
Measure vital capacity	Resp Team	