

HOLY CROSS HOSPITAL



2014

Clinical Outcomes Report

BACKGROUND

The Congregation of the Daughters of the Cross was founded by the blessed Marie Therese in 1833 in Liege, Belgium. The Congregation arrived in England in 1863 and in Haslemere in 1917 with the transfer of the sanatorium from Margate. In 1948 at the time of the Health Act the Sisters were invited to become part of the NHS. They declined preferring to retain choice and control but agreed to continue to provide services for the NHS.

Holy Cross Hospital as it is today was opened in 1992 and extended in 2009 with the addition of the hydrotherapy pool and outpatients' physiotherapy gym. It provides highly specialised services for people with severe and complex conditions in a comfortable, homely, modern environment.

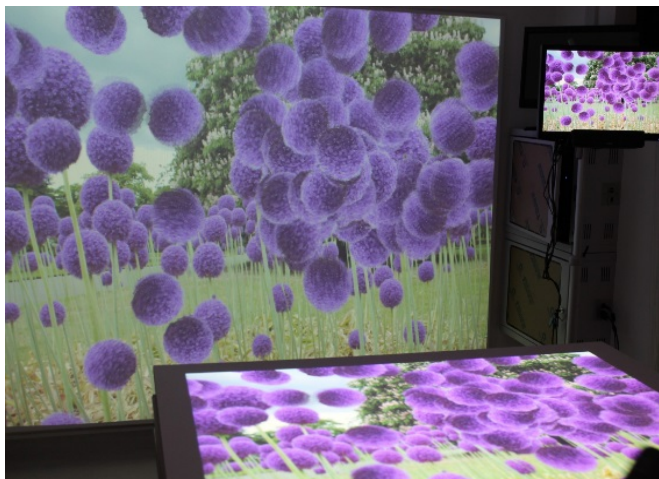
Facilities

Set in very attractive grounds with beautiful views the hospital has 40 single rooms with en suite facilities complemented by spacious, superbly equipped communal areas and treatment rooms used for therapy and leisure.

St Anne's Sensory Technology room was officially opened by The Countess of Wessex in July. The room has various pieces of equipment including:

Eye Gaze system and software - accessed via an adaptable monitor and laptop it has many graded programmes, which can be used for assessment, therapy and activities. The equipment is mobile and therefore enables the therapists to provide therapy sessions in a patient's room in addition to the Sensory Room.

Optibeam - enables users to interact with beams of light projected from the ceiling by passing a hand or other body part through the beams, or by using a handheld reflective paddle. Each interaction triggers audio-visual sequences in real time and can be activated by one action or multi-actions by one or more people



Magic Carpet - projects interactive images onto a table, the patient or the floor, which can be easily controlled by moving across or over the projected image. The system can easily be customised to suit individual needs and requirements and interface with the other equipment in the room

The room and equipment has further enriched our already extensive therapy and activity opportunities and been a direct benefit to a large number of our patients.

As well as spectacular views and gardens there is a wheelchair accessible woodland trail and a senses garden which was specially designed to meet the specific needs of our patients.

Access to the wider community is important to patients and their families. There are many leisure facilities including shops, cafes, garden centres, theatres, leisure centres, cinemas and accessible scenic viewing points within a short drive of the hospital.

Visitors comment on the warm, welcoming atmosphere of the hospital.



OUR STAFF TEAM

Our staff team across the whole hospital are committed to making our patients' lives as fulfilling as possible and giving their families peace of mind. Our clinical team consists of a wide range of professionals with expertise in the management of severe, complex disability. The team is led by a Consultant in Rehabilitation Medicine and includes Hospital Doctors, Consultant Neuropsychologist, Nurses, Physiotherapists, Occupational Therapist, Speech and Language Therapist, Dietician, Activities Organisers and Art Group Leader. All are highly motivated to work with the patient group and have high levels of skill and knowledge. Our main aim is to provide the best possible quality of treatment and care focusing on what each individual patient **can** achieve rather than highlighting their difficulties.

Our team of volunteers are vital to ensure we are able to provide a wide and varied range of activities for our patients both in and outside the hospital. The Friends of Holy Cross continue to give a lot of their time raising funds for the added extras that make such a difference.

The contribution of each member of staff is highly valued and there is a commitment to helping each one develop to their full potential through substantial investment in a comprehensive learning and development programme. Continuing professional development is carried out systematically; the clinical staff team are supported in professional portfolio development and maintenance. Clinical supervision is ongoing and takes the form of specialist teaching, actual case study analysis, journal club and peer group supervision. A comprehensive competency framework and assessment is in place with support to ensure all staff members are competent in their professional area. Evening meetings are held for volunteers to provide support and opportunities for training and discussion.

The hospital is accredited with the Investors in People award.

OUR WORK

We provide highly specialised individualised rehabilitation and care for people with extremely complex needs as a result of profound injury or a serious neurological condition. Our approach is centred on the patient as a whole person placing strong emphasis on making their lives as fulfilling as possible and supporting them to come to terms with living their lives differently and we help them to do that. Support to families and friends is a high priority and we welcome their participation.

We involve our patients as much as they are able. Patient forum meetings are held every week and provide opportunities for seeking patients' views, new ideas and suggestions.

Assessment

Prior to admission each patient has an assessment to ensure their individual needs can be met, identify any special equipment that may be required and inform costings. This includes assessment of their medical and physical status, level of awareness and cognitive ability. Initial goals are identified with the patient and/or family; this begins the first stage of the relationship. Prior to admission, patients and/or families are actively encouraged to visit Holy Cross to view the facilities and meet the team. A comprehensive report is prepared for funding authorities and approval for funding requested.

Further in depth assessment takes place after admission to plan appropriate treatment and care, develop a person centred care plan and agree goals which take into account short, medium and longer term aims.

Six weeks after admission a patient and family meeting is held with the team to discuss results of assessments, progress and future plans.

Re-assessment and review is a continuous process, timescales for formal review meetings are determined according to individual patients' individual needs and changing condition.

Clinical practice

Our clinical practice is evidence based and focuses on achieving the best possible outcome for each patient by preventing complications, maximising their potential and minimising the impact of the injury or illness.

Clinical governance

Clinical governance is an approach whereby all areas of patient care are systematically reviewed and changes implemented to ensure services are quality driven with minimal risk.

Clinical governance is led by our Therapy Services Manager and the Clinical Governance Group. A Clinical Governance strategy and a programme of objectives and supportive actions are agreed each year; the group meet regularly to plan, review and monitor and evaluate activities and practice.

Clinical audit

A planned programme of clinical audit is in place to provide a systematic method for reflection and review of practice. Changes to practice and organisation of patient care is based on evidence including collection of data and an open and honest reporting structure. Audit reports are shared with management and staff for implementation of appropriate recommendations. The audit programme in 2014 demonstrated a high level of compliance with standards and all recommended actions were implemented.

CARE QUALITY COMMISSION INSPECTION 2014

Our Inspector from the Care Quality Commission carried out an unannounced inspection visit on February 25th 2014. During her visit she looked at the personal care/treatment records of patients, checked and observed how people were being cared for at each stage of their treatment and care. She spoke to patients and families, talked

with staff and reviewed information given by the Provider. We were inspected against five standards and found to be meeting all of them. The standards included:

- Consent to care and treatment
- Care and welfare of people who use services
- Cooperating with other providers
- Staffing
- Assessing and monitoring the quality of service provision

A selection of findings from the report is shown below:

People we spoke with were very happy with the services provided by Holy Cross Hospital. One person said; "This is better than most places I have been to." And; "It took me a while to get used to but now I can't think of a better place." Another person said; "I'm very happy here, I can't fault the place."

People said staff worked hard to make sure their needs were met and we were told that staff were attentive and helpful. One person commented; "Staff are brilliant." And another commented; "The staff are excellent, if you ring for them they come straight away and even if they are busy they will come and tell you they will come back as soon as they have finished with another patient."

We found there was knowledge and awareness of neurological care in the service. The management team were aware of good practice guidelines and the latest research relating to the care and treatment of neurological conditions and these were incorporated into the care provided by the hospital. We found staff were knowledgeable about how to care for people with neurological and associated conditions.

We found people's privacy and dignity were respected and staff involved patients as much as possible in decision making. We saw that the service went to great lengths, and with the use of new initiatives in technology and adaptations, assisted people to continue to interact with their surroundings.

Everybody we spoke with said they were fully consulted about their care and treatment. People told us continuity of care was very good. One person said; "It is a wonderful facility."

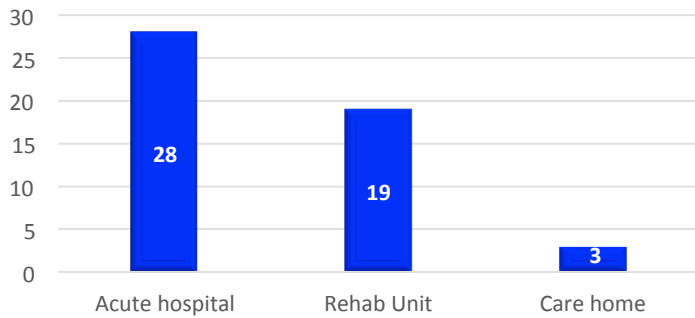
OUR PATIENTS

Our patients at Holy Cross have a wide range of disabilities including profound physical disability and almost total paralysis. Some have such severe impairments that communication and interaction with other people is difficult and disjointed with many of them are living more or less in the moment.

Occupancy

Our occupancy rates remained high during 2014. We admitted ten new patients and discharged three; one to a specialist care home, one to his own home and the third returned to her care home after a short term rehabilitation programme. Eight patients died, five following transfer to an acute hospital. In total 50 patients were treated during the course of the year excluding our two regular respite patients who were admitted for short periods when a bed was available.

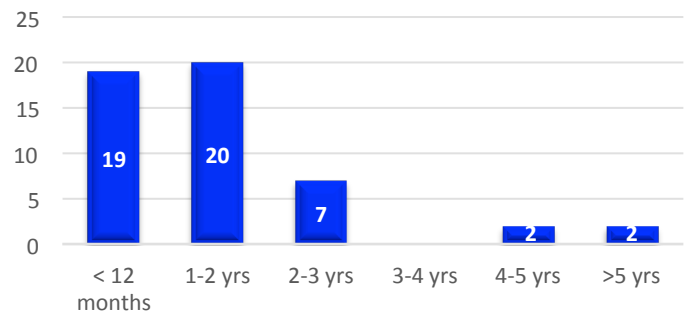
Admission sources



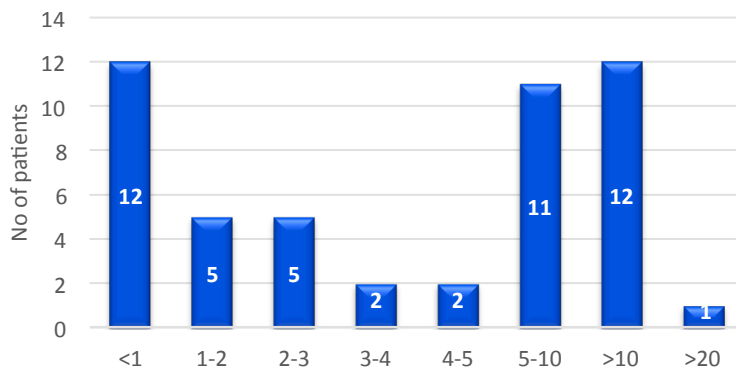
The majority of our patients were admitted directly from an acute hospital or acute rehabilitation unit. One patient was admitted from a care home for a short spell of rehabilitation.

The time between injury or onset of illness and admission to Holy Cross ranged from three months to several years with most patients being admitted within one year.

Onset of injury/illness to admission

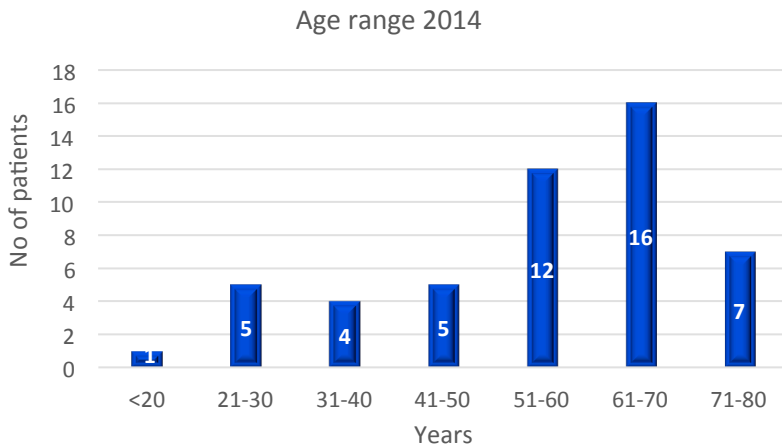


Length of stay (years)



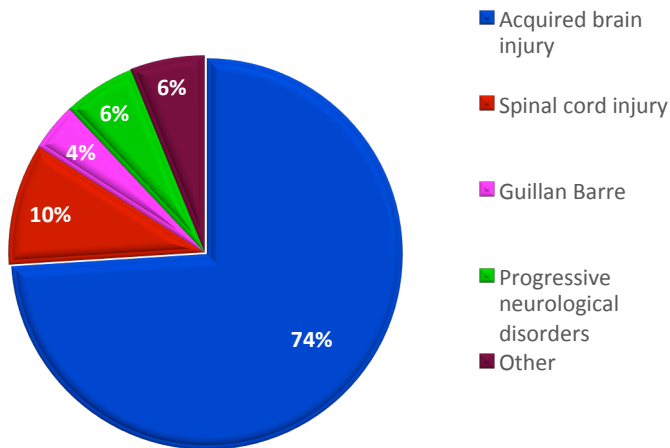
Just over half of all patients have been resident less than five years.

Age and gender of our patients during 2014



The percentage ratio of males to females in 2014 remained constant at 66/34. Our youngest patient was 17 years and the oldest 80 years. The age range of patients in 2014 is shown in the adjacent chart.

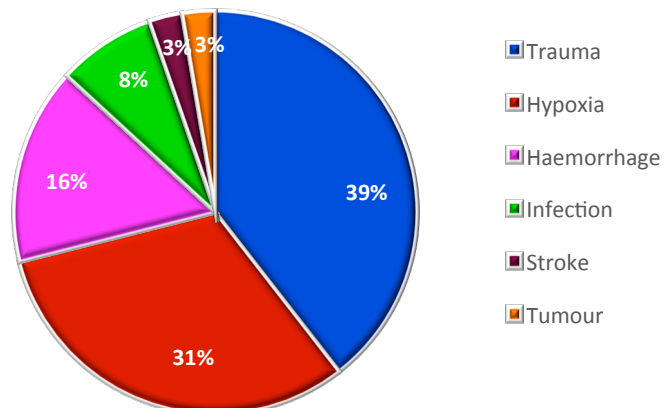
Patient diagnoses in 2014



The largest diagnostic group continues to be acquired brain injury. Progressive neurological disorders included Motor Neurone Disease and Parkinson's disease. Spinal Cord injuries were all at a high level in the spine and required mechanical ventilation. The 'other' category included Idiopathic Myopathy and Chronic Pain. The charts show the diagnostic groups and causes of acquired brain injury in patients treated during 2014.

Trauma was the most frequent cause of acquired brain injury closely followed by hypoxia.

Causes of acquired brain injury in 2014



EFFECTS OF NEUROLOGICAL CONDITIONS

Patients with neurological problems present with a wide variety and complexity of effects. The most frequently occurring at Holy Cross include:

- Disorders of consciousness
- Impaired cognition
- Behavioural disorders
- Respiratory difficulties
- Swallowing disorders
- Bowel and bladder problems
- Immobility, spasticity and other physical problems

Disorders of consciousness

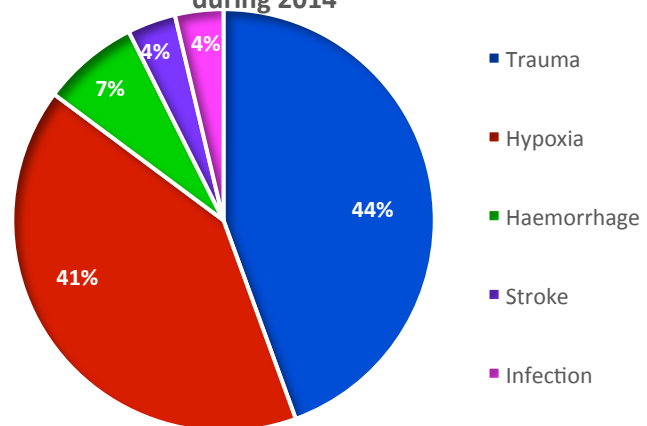
Following a profound brain injury some patients remain in a vegetative or minimally conscious state, such patients are described as having a prolonged disorder of consciousness (PDOC). They require repeated, skilled assessment as their level of awareness may change over time. Caring for this group of patients requires expert nursing and skilful therapy interventions and can be clinically demanding. They are unable to tell us what they want or if they are in discomfort or pain so staff have to monitor them closely and anticipate their every need. By the nature of the condition they lack capacity to make decisions regarding their care and treatment so these have to be made for them in their best interests which will vary from patient to patient.

Families of patients with a disorder of consciousness may suffer severe distress and need support and help to come to terms with the drastic changes in their lives resulting from the profound injury of a loved one and the associated uncertainty. It is important to involve them in clinical decision making as they are most likely to be able to tell us what the patient would want if he/she could tell us.

The commonest causes of profound brain injury resulting in a prolonged disorder of consciousness are trauma and hypoxia (interruption or reduction of oxygen supply to the brain).

We treated 27 patients diagnosed as having a disorder of consciousness during 2014.

Causes of prolonged disorders of consciousness during 2014



We reviewed and rationalised our assessment tools in line with the National Clinical Guidelines (Royal College of Physicians 2013) and used the Wessex Head Injury Matrix (WHIM) on all patients. This is formal assessment that enables patient's behaviours to be observed when being exposed to specific stimuli which includes basic responses which are reflexive in origin, purposeful responses leading to social interaction and actions, attention and cognitive as well as organisation and orientation ability. It has been noted on analysis of the WHIM data that the highest scores achieved for an individual has been facilitated using the sensory equipment latest technology. This has enabled structured replicable stimuli to inform the assessment process.

Patients scoring three or more on the WHIM were further assessed using the Coma Recovery Scale–Revised (CRS-R). This is a formal assessment divided into six subscales - Communication, Auditory, Visual, Motor, Oro-motor, Arousal. It provides specific assessment in these domains, which enables the team to target and facilitate patients' strengths and deficits in specific domains for treatment opportunities.

In addition we introduced a simplified assessment tool to be used by family and friends and compared observation with those of clinical staff and found no significant differences.

The Sensory Technology Room now has all of its main equipment with internet access; this again has further extended opportunities for the patients by providing up to date interests information and programmes.

Impaired cognition

Cognition refers to our mental abilities e.g. speed of thought, understanding, memory, concentration, problem-solving, insight and using language. The cognitive system is located in different areas of the brain; the parts work independently but are interrelated. An injury to the brain will shake it up with some parts being damaged and some left intact. We treated 13 patients with cognitive impairments during 2014.

Various standardised assessment tools including the Mini Mental Health Test, BECKs Depression Scale, Lowenstein Occupational Therapy Cognitive Assessment (LOTCA) and Addenbrooke's Cognitive Examination - Revised (ACER) were used to establish a baseline of cognitive function for patients with identified cognitive problems. The results informed treatment planning and enabled all 13 to actively participate in a full social activities programme including outings with families and visits home.

Behavioural disorders

Changes in behaviour commonly occur after a brain injury; many are minor and cause no problems. When the changes are significant the patient can be difficult to deal with and there is a risk of him/her becoming excluded and isolated. It is one of the greatest causes of stress to families. We treated 10 patients with mild to severe behavioural disorders. Types of behaviours observed included:

- Irritability, verbal and physical aggression
- Impulsivity
- Disinhibition/inappropriate social behaviour
- Lack of drive, initiative and motivation
- Lack of insight
- Inflexibility
- Mood swings
- Egocentricity

Detailed behaviour management guidelines were established and followed using a consistent approach and all were supported to join in activities including outings with families.

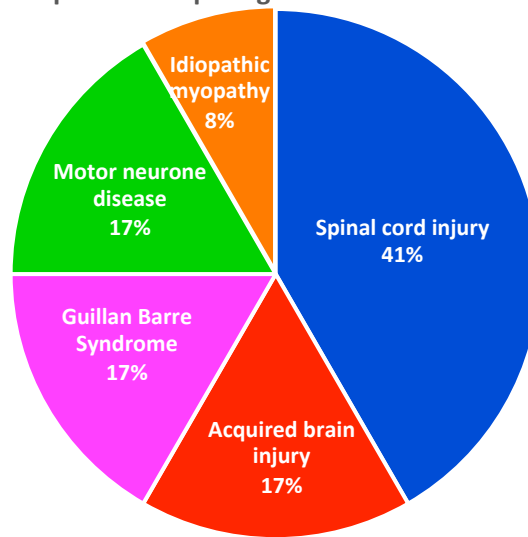
Respiratory difficulties

We specialise in treating and caring for patients with potentially complicated respiratory conditions including respiratory failure usually as a result of high level spinal cord injury, acquired brain injury, Guillan Barre Syndrome or a degenerative neurological disorder. Many have a tracheostomy and an increasing number require mechanical ventilation.

The total number of patients needing a tracheostomy to maintain a safe airway or facilitate mechanical ventilation during the year was 24.

The number of patients requiring mechanical ventilation during 2014 was 12. The highest number treated at one time was eight. All were managed well with no unavoidable complications. Where appropriate and safe we introduced a weaning programme with the aim of reducing the time patients were reliant on the ventilator. One patient was completely weaned from the ventilator and tracheostomy and was subsequently discharged to his own home. Five other patients were able to reduce their number of ventilated hours per day.

Diagnoses of patients requiring mechanical ventilation 2014



Swallowing disorders

Swallowing problems are common in patients with neurological disorders and in those who need mechanical ventilation or tracheostomy for breathing. Swallowing problems arise from changes in the anatomy in the throat by the tracheostomy tube or changes in the systems that control, sensation, taste and muscular control. All of which are vital for safe swallowing.

Many of our patients have swallowing problems caused by a combination of difficulties and are at high risk of choking or aspirating food or fluids into their lungs. Some are at such high risk of choking or aspiration they require feeding via a tube placed directly into the stomach. In most cases this is a percutaneous endoscopic gastrostomy (PEG).

A very high number of our patients (41) required enteral feeding via a percutaneous gastrostomy tube (PEG); four of them were able to take food orally but need additional nutrition via the PEG; some (seven) were able to tolerate very small amounts orally for pleasure (tasters).

Bowel and bladder problems

Dysfunction of the bladder and/or bowel in patients with neurological disorders is frequently due to malfunction of the nerves which control function. The nerve pathways can be damaged at any point; the problem occurring depends on location and extent of damage. The problems are widespread and may be a combination of difficulties; 47 out of the 50 patients treated had difficulties in this area. Various management regimes were used to minimise the impact on patients. Urinary catheters were used as a last resort only after other options had been explored and failed.

Immobility, spasticity and other physical problems

Immobility is a very common consequence of a neurological disorder. Posture management forms the major part of the physical management; a twenty-four hour approach is necessary for safety, comfort and to prevent complications such as contractures or pressure ulcers. Each patient was assessed and the necessary aids for optimum positioning provided. Consistency during the whole 24 hour period is vital so very detailed care plans and photographic positioning guidelines to act as a point of reference were provided.

Wheelchair mobility

All patients were assessed and provided with a suitable wheelchair to meet their needs. All wheelchairs were audited every six months and any works required requested via the providers of the chairs.

Spasticity management treatment options

One of our main treatment interventions is spasticity management. Spasticity is over activity in the muscles, which follows damage to the brain or spinal cord; it may take the form of sustained high tone, intermittent spasms or a mixture of the two. In simple words it is tightness of the muscles. Uncontrolled spasticity leads to contractures, which are described as permanent shortening in the muscles and soft tissues.

We used a variety of treatments for the management of spasticity including oral medication, intrathecal treatment using Phenol or Baclofen, focal treatment using Botulinum Toxin type A and physical treatment e.g. physiotherapy, splinting, positioning.

The mainstay of treatment was physical and involved:

- Careful positioning throughout 24 hours to maintain muscle length and reduce deformity
- A regular physiotherapy programme, which may include stretching and splinting
- Active treatment of exacerbating factors such as infection, pain, constipation and other nociceptive influences

DEPENDENCY LEVELS OF PATIENTS IN 2014

Our patients remain highly dependent needing detailed care planning, skilled care and treatment to maximise potential for improvement and prevent complications. The complexity of patients referred or admitted

continues to increase with a high proportion requiring tracheostomy and mechanical ventilation. Dependency levels were based on complexity and measured using the Rehabilitation Complexity Scale.

Rehabilitation complexity scale (RCS)

This is a simple easy to use assessment tool which identifies the level of skilled intervention from qualified therapists and nurses. It clearly demonstrates the complexity of each patient and the hospital as a whole by assessing patients' needs (actual or approximate) in six areas including:

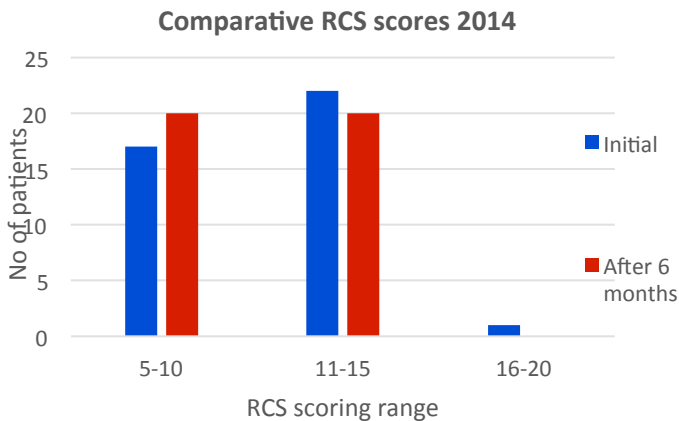
- Basic care and support –0-4
- Skilled nursing – 0-3
- Medical – 0-3
- Therapy intensity – 0-4
- Number of therapy disciplines – 0-4
- Equipment – 0-2

Each section is scored and scores are added together. Scores range from 0-20 with 20 being the highest. Higher scores represent greater complexity.

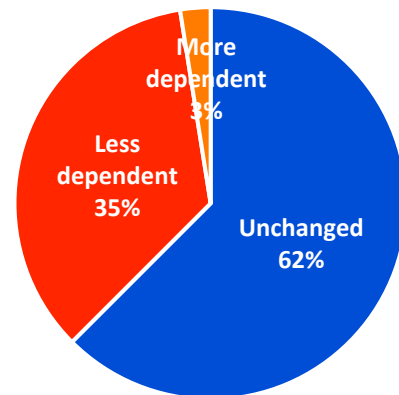
OUTCOME MEASUREMENTS

Rehabilitation complexity scale

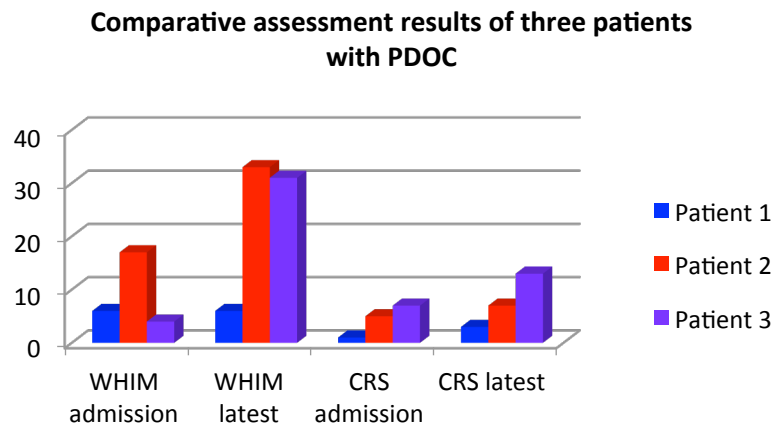
We completed assessments on all patients during 2014, 40 were repeated after six months.



Changes in levels of dependency using RCS



Using WHIM and CRS-R we compared data for three patients, which shows correlation between observed behaviour's on the WHIM and the sensory domain on the CRS- R. This reflects a consistency in the patients' response across both assessments.



Technology

The Sensory Technology Room now has all of its main equipment with access to the internet, this again has further extended opportunities for the patients by providing up to date interests information and programmes.

Examples

Patient A – is unable to use a switch effectively and has benefited from being able to build his skills in eye gaze access using the sensory equipment. He has progressed to using the gaze selection to access the internet to look at websites e.g. You Tube and news channels/current affairs he is interested in.

Patient B – has used the combined systems of eye gaze, magic carpet and Optibeam to facilitate cause and effect in a patient with a disorder of consciousness allowing us to chart progress from vegetative to minimally conscious state.

Patient C – has used the system to strengthen functional ability in her upper limbs with support from a mobile arm support system. She has been able to actively maximise her range of movement using the Magic Carpet. The support of the mobile arm support enables the patient to become less fatigued whilst exploring a variety of stimulating or therapeutic programmes.

We have enabled two patients to try the head mouse and are keen to embrace new technology that can benefit our patients. We have been trialling new software to enable eye gaze communication called communicator with very effective results.

We have moved forward on enabling some of our patients' independence with accessing their environments using basic switching systems and more complex tablet computer systems including infra-red transmitters and iPad/iPod systems.

Wheelchair mobility

We assessed and enabled three patients to become independent with controlling their wheelchairs by chin control. One other patient was helped to acquire a more suitable chair to meet his independent mobility needs. These patients were unable to mobilise independently when first admitted to Holy Cross Hospital.

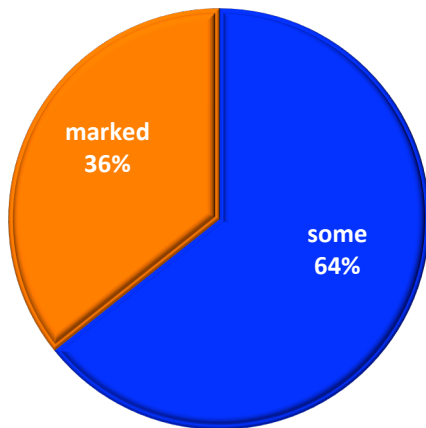
Access and discharge planning

We have completed a number of home assessments this year to enable our patients to spend time at home or to return to their own homes with support. This has included complex planning and specifications for major adaptations, working closely with outside agencies to provide a smooth transition to either home or on to other care options. We continue to work on assisting patients who wish to return home. It requires an MDT approach to all aspects of discharge planning to enable the patient to return home with a care package that meets their needs within a safe environment. It can take many months to realise a discharge due to the complexity. During 2014 we successfully discharge one patient and expect another highly complex patient to be discharged early 2015.

Treatment of spasticity

Botulinum Toxin

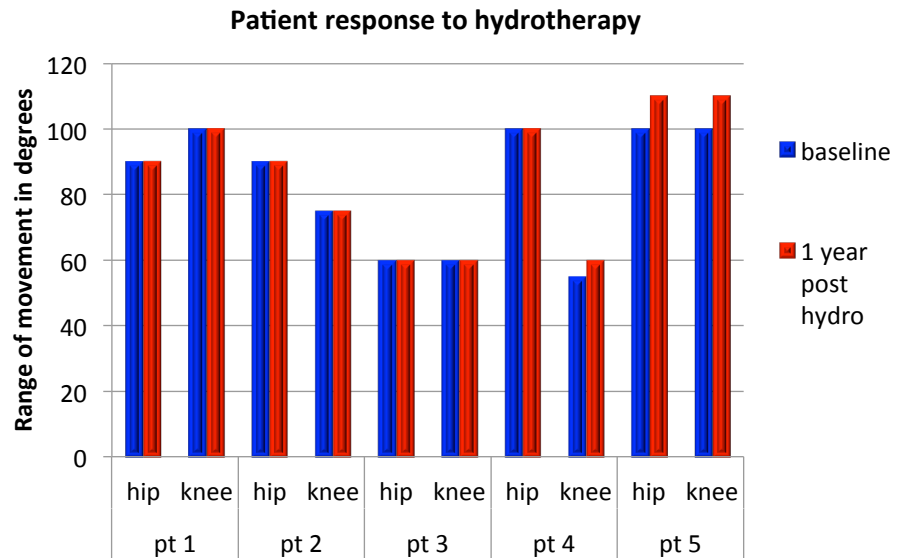
Response to Botulinum Toxin as a treatment for spasticity



During 2014 we treated 12 patients with Botulinum Toxin injections to manage high muscle tone or spasticity; some had more than one cycle of injections. Nine patients had some effect from the injections and five patients had marked effect. The outcome data collected were Modified Ashworth Score (MAS) which measures the tightness in the muscles and the joint Range of Movement (ROM) of the joints. All patients received post injection physiotherapy including splinting and stretching in line with the Royal College of Physicians Guidelines (2009).

Hydrotherapy

Following assessment 16 patients were treated in the hydrotherapy pool during 2014. Patients received a block of treatment sessions and then had a break as indicated. The chart shows the joint range of movement (ROM) of five patients who regularly attended hydrotherapy in 2014.



Splinting

Splints are used by therapists to achieve a variety of clinical benefits including maintaining the effects of physiotherapy, preventing tightness, management of muscle tone, prevention of deformity, improving range of movement, enhancement of hygiene and prevention of skin breakdown. They are used in conjunction with other interventions e.g. post Botulinum Toxin stretch. More than 90% of the splints used at Holy Cross Hospital are fabricated in-house by our therapy team using thermoplastic or fibreglass materials. The upper limb and lower limbs are the predominantly splinted body parts. Splints may be applied when patients are sitting up in wheelchair or when in bed. At present 27 patients at Holy Cross Hospital are using a total of 62 splints (44 upper limbs and 18 lower limbs).

COMPLICATIONS

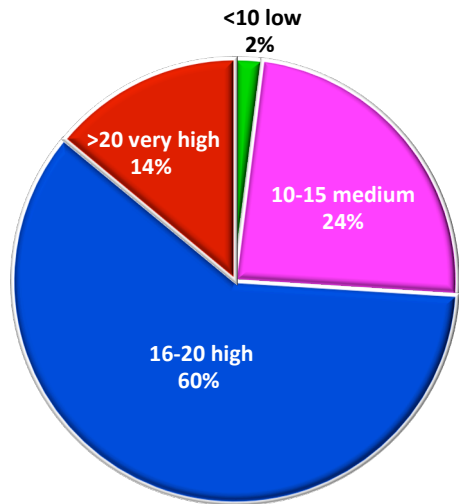
Patients with highly complex needs such as those treated at Holy Cross are at great risk of developing complications including:

- Pressure ulcers
- Contractures
- Infections

Pressure ulcers

A pressure ulcer is damage to the skin caused by external forces, which may lead to tissue death usually over a bony prominence. They may be caused by pressure when the blood supply is reduced by compression of tissue between bone and a hard surface; if this is combined with friction serious damage may be caused. Another possible cause is a patient sliding down the bed moving the skeleton and tissues but not the skin; this can lead to extensive damage.

Risk of pressure ulcers using Waterlow Scale 2005



All patients are assessed on admission using the Waterlow Scale (2005). Assessments are repeated if indicated by a change in a patients' condition. During 2014 37 patients (74%) were at high or very high risk of developing a pressure ulcer. Eight developed a grade 1 or 2 pressure ulcer; all healed well with minimal intervention.

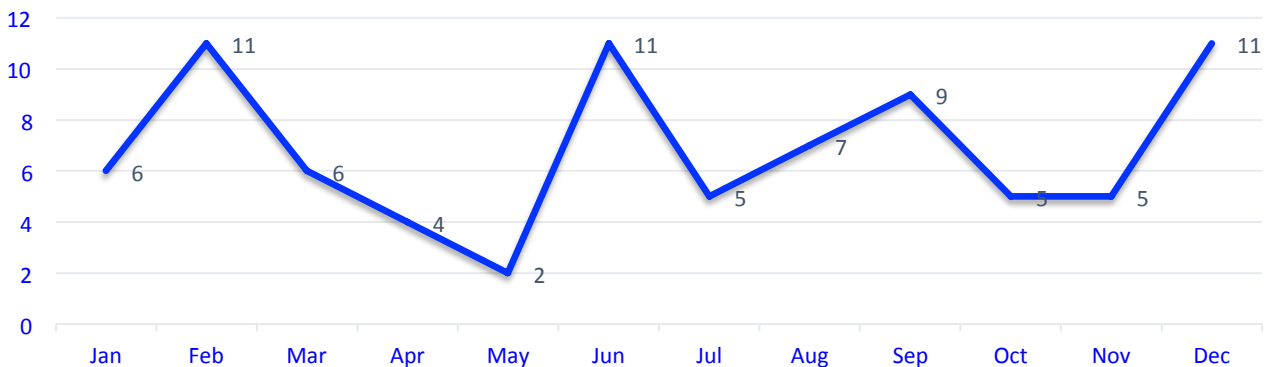
Contractures

Thirty-five of our patients were identified to be at risk of developing contractures during 2014 by the presence of spasticity and lack of active movement. Five (14%) Patients improved their joint ROM due to active exercise programme, specialist spasticity management and regular physiotherapy. Twenty-six (75%) patients did not change and four (11%) patients deteriorated. In patients who deteriorated or developed a contracture the causes were identified as deteriorating medical condition, patient noncompliance, worsening/uncontrollable spasticity and active posturing leading to reduced joint range of movement.

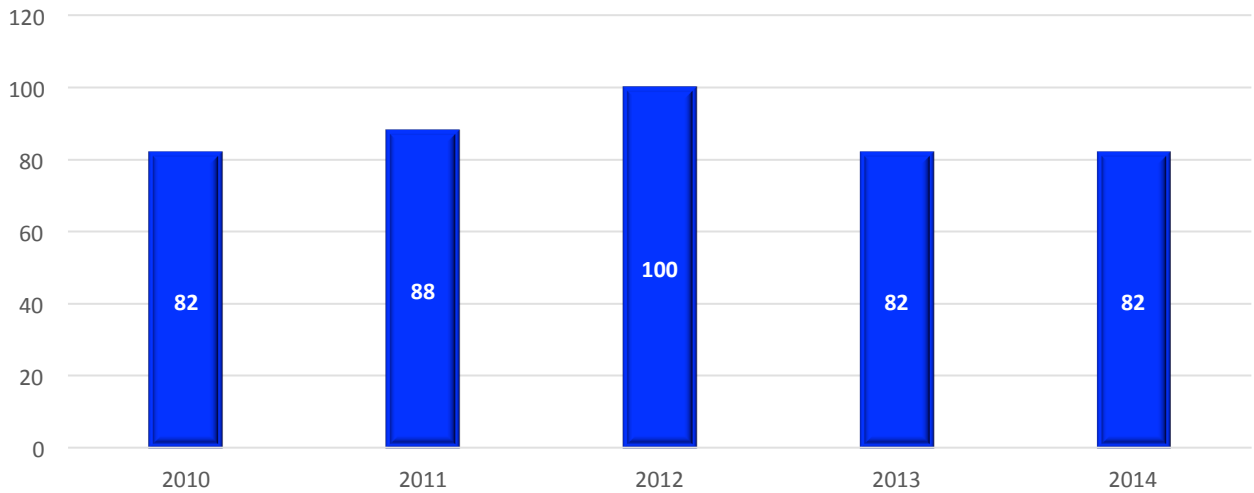
Infections

There were 82 reported infections in 2014 affecting 24 patients in 2014; this is a similar result to 2013. Eleven patients had no infections and 15 had only one. The highest number of infections suffered by one patient was nine. Systemic antibiotic treatment was prescribed in 66 cases.

Total no of infections 2014

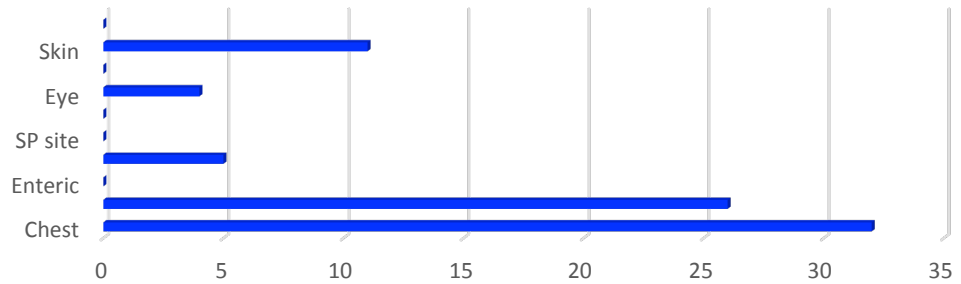


Total annual infection rates 2010-2014



The commonest site of infection in 2014 was chest followed by urinary tract infection.

Sites of infection 2014



URGENT ADMISSIONS TO ACUTE HOSPITAL

Nine patients were transferred to an acute hospital for urgent treatment.

ACTIVITIES PROGRAMME

Many varied activities involving our patients and their families took place during the year both in and outside the hospital. Outings included trips to the theatre and cinema, meals out in restaurants, visits to local beauty spots and many more. The homely and sociable environment of the Sisters' holiday cottage in Selsey was very much appreciated by our patients and their families with long lasting friendships being forged during these trips. Some of our patients visited their family homes for the first time in many months; the meticulous planning and commitment of resources was well worth it. It is not possible to put a value on this precious time.

100%
Happy with
social
activities

The senses garden and woodland trail were well used especially during the glorious summer months. A major benefit of these areas is the opportunities for conversations to develop particularly for families and friends who sometimes find it hard to have a conversation that with many patients is one way. We are fortunate to have such splendid facilities to provide varied opportunities to enhance quality of life through allowing connections that would otherwise not be made.

We constantly strive to make the hospital an interesting and stimulating place to be for our patients. The work of the patients' activities staff and volunteers is pivotal to achieving this. Our success in this area was demonstrated once again in the annual survey with 100% of respondents happy with social activities available.

FEEDBACK FROM PATIENTS AND FAMILIES

We welcome feedback from our patients and their families so every year we ask them how satisfied they are with different aspects of our service. We use the NHS standard survey questionnaire and repeat it every year. The response rate this year was 48% slightly lower than average. Overall opinion of the Hospital remains very high.



The last section of the questionnaire invites comments. The majority were very positive, illustrated by the following examples:

- *The Holy Cross Hospital is generally a wonderful and caring establishment and we feel the patients are in a safe and happy environment.*
- *I love Holy Cross!!*
- *I wish every hospital worked as well as Holy Cross.*
- *The Care provided by Holy Cross is excellent and means I have peace of mind.*

ACHIEVEMENT OF PLANS FOR 2014

Research project – ‘A prospective case series to investigate current practice in the physical management of people with disorders of consciousness and its impact on the pattern of limb and spinal deformities’ is ongoing.

We held our conference entitled Recent Advances in the Assessment, Diagnosis and Multidisciplinary Management of People with Disorders of Consciousness over two glorious sunny days in June. The conference was a great success and attended by over 120 delegates. Extremely positive feedback was received from delegates and speakers.

We have reviewed the guidance published in December 2013 by the Royal College of Physicians on Disorders of Consciousness and our practice. We have implemented assessment and treatment programmes based on the guidelines.

St Anne’s sensory technology room is in regular use for the assessment, intervention, skills training and enjoyment of patients. We have introduced key objectives which are measurable and will aid and inform our patient care.

A new schedule of patients’ activities which are published monthly have been introduced and well received by patients. Patients have participated in the production of a quarterly newsletter.

The hydrotherapy foundation course was well attended and excellent feedback received.

Installation of piped oxygen and suction project is ongoing.

LOOKING FORWARD TO 2015

2015 will see us continuing to work to consolidate our expertise in the management of this highly complex patient group whilst striving to achieve further improvements in our services. Specific areas of work planned include:

Research project

A prospective case series to investigate current practice in the physical management of people with disorders of consciousness and its impact on the pattern of limb and spinal deformities is ongoing and expected to be completed for publication by the end of 2015.

Cochrane review

Assistive technologies including orthotic devices for management of contractures in stroke will be completed and published by the end of 2015.

Sharing good practice

Good practice article on Improving the Quality of Life for Patients Needing Long Term Ventilation will be submitted for publication to relevant nursing journals.

Improving clinical practice

We will continue to work with patients in goal setting and implement a system to measure successes and identify reasons for under achievement of goals.

Sharing good practice

We will hold further hydrotherapy courses and introductory BoBath (specialist neurophysiotherapy treatment approach based on normal movement) modules.

Developing services

We will introduce an Associate Nurse Programme to support overseas nurses to gain registration with the Nursing and Midwifery Council and provide us with a constant stream of registered nurses to enable us to expand our services.

Improving clinical practice and developing services

We will explore the new role of Practice Development Manager to support research and service development.

Improving patients' experience

We will continue to review patients' activities involving patients to ensure the hospital continues to be an interesting and stimulating place for patients.

CONCLUDING REMARKS AND ACKNOWLEDGEMENTS

We have achieved a great deal during 2014, which has once again seen us delivering a very high quality service that has been appreciated by patients, families, referrers and funders. Our patients continue to present us with greater challenges each year and I am confident they are in safe hands and being cared for by people who value and respect them and recognise them as individuals in their own right.

Our strength is our outstanding staff team whose exceptional skill, motivation and attention to detail is impressive. They remain professional, good humoured and enthusiastic whatever challenges they encounter. This is not only staff who work directly with patients it is also those working behind the scenes without whose contribution the hospital would very soon grind to a halt.

Our team of volunteers and the Friends of Holy Cross deserve special recognition for their work in bringing added value by helping in patients' activities, driving the ambulances, shopping for patients and fund raising. We couldn't do it without them.

We are privileged to have the opportunity to continue the Sisters' work in healthcare with their support, guidance and enthusiasm which is in abundance.

I look forward to working with this very special team in 2015 as Holy Cross continues to provide excellent service to people with extremely complex needs.

With special thanks to Rasheed Meeran, Therapy Services Manager; Gina Guo, Nursing Services Manager and Judi O'Neill, Specialist Occupational Therapist for their contributions to this report.

Carol Fowlie, Director of Clinical Services
January 2015

Annabelle

Annabelle is a 49. Prior to her illness she was working part time as a therapist and was fit and active. One of her main interests is her two dogs. In January 2013 she developed left shoulder pain and generalised weakness. Following investigations a diagnosis of Guillan Barre Syndrome was made. This is a rare and serious condition of the peripheral nervous system. It occurs when the body's immune system attacks part of the nervous system. Patients suffer pain, tingling, numbness problems with co-ordination and progressive muscle weakness. In some cases the respiratory muscles are affected. Eighty per cent make a full recovery but some will have long term problems.

Annabelle continued to become progressively weaker and by the middle of February she was unable to breathe without the assistance of a ventilator and tracheostomy. She suffered a further setback one month later when she had a cardiac arrest and needed a pacemaker.

After five months rehabilitation Annabelle arrived at Holy Cross in December 2013 with very little movement and completely dependent on staff. She needed the ventilator 24-hours per day and continuous oxygen. She was unable to swallow anything at all and all nutrition, fluids and medication was administered via a PEG.

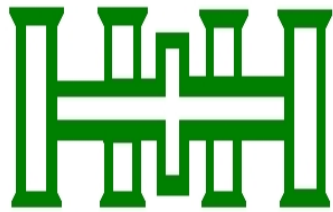
From the beginning Annabelle made it clear her main goal was to return home to her husband and dogs. Following a comprehensive assessment and with Annabelle's involvement we worked with her on:

- Ensuring she was as medically fit as possible
- Increasing her comfort by controlling her pain by medication and provision of bespoke slings for hoist transfers
- Weaning her from continuous oxygen
- Maintaining neck and upper limb strength and active range of movement
- Increasing her independence by using high tech environmental controls
- Facilitating her to use a chin control micro joystick to use her computer
- Re-assessing her wheelchair and adapting it to increase comfort
- Assessing her ability to use a powered wheelchair using a chin control and arranging provision
- Planning a regular routine to manage her care needs which could be replicated in her home
- Assessing her swallowing with the aim of her being able to have a cup of coffee
- Undertaking visits to her home and advising on adaptations
- Going out to the theatre

Annabelle was extremely motivated and spent many hours in the sensory technology room working with therapy staff to strengthen her upper body and increase her range of movement.

Annabelle was closely involved in planning her discharge and chose her new kitchen, bed linen and soft furnishings using her computer as well as keeping a close eye on the changes being made in her home. Her first visit home was on a sunny day in September; a very emotional day for Annabelle, her husband and also the staff. At last the dream seemed a reality.

At the time of writing Annabelle does not need oxygen; she spends short periods each day off the ventilator. She is independent in her room using technology and spends several hours a day talking to her family and friends using Skype. She has two wheelchairs one of which she operates independently using a chin control. She enjoys regular cups of coffee and has been to the theatre several times. After many hours of planning, working with external agencies and training carers. Annabelle is looking forward to being discharged home at the end of January or early February 2015 when the dream really will come true.



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