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THE RESETTLEMENT PROCESS

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THE resettlement at home of a paraplegic or tetraplegic patient is not an event, it is a process, and sometimes a lengthy one. It is both necessary and justified that much time should be spent by hospital staff and by local authority officers in making arrangements for the patient's home-coming. It is well known that preventive medicine is a good investment and a sound and painstaking resettlement does a great deal to prevent the later complications of paraplegia.

All who are concerned with spinal cord injury realise that, nowadays, the greatest remaining scope for the further improvement of our patients' prognosis lies not only in getting the home care right but in getting it right from the beginning. It is recognised that the early stage of home care is a period of high risk. Independence in hospital is one thing but on returning to an unprepared home, this hard-won independence may be lost. All too often sores and urinary infection develop in the first few months and such set-backs are very destructive to the self-confidence of the patient and his family.

To achieve a good home resettlement many letters are written and frequent telephone calls are made but this is mere 'paper currency' compared with the 'gold' of personal contact between hospital staff and the local authority officers. It is difficult for spinal injury units, having such large catchment areas, to get to know local authority staff at a personal level. All spinal injury units evolve their own procedures for preparing a home and family for the discharge of a rehabilitated patient. At Oswestry the procedure has gradually developed and in the past five years it has been built around the home visiting follow-up nurse.

Although one cannot do much directly in the way of resettlement in the first ten weeks after injury it is, even so, a stage of preparation and not simply a matter of wait and see. Hospital staff get to know more about the patient's condition and prognosis and they get to know more about the home and family of the patient.

During the second ten-week period, by which time the permanent disability can be assessed, letters are sent to the local authority social and nursing services and to the Area Medical Officer. The patient's closest relatives are invited to come and spend one or two weekends in the hospital during which time they are intensively coached in nursing care. It is in this period that the first reconnaissance visit is made to the patient's home. Whenever possible, distance allowing, the patient himself accompanies the resettlement nurse on this initial home visit.

The local authority social worker and district nurse are asked to come to a discussion in the patient's home at the time of this first visit. There is, on the whole, a very good response to these invitations. At the conference the questions of house alteration and equipment are discussed.

Following the first reconnaissance visit, and the patient's condition permitting, there begins a regular pattern of weekends at home. Patients and their families learn much from these intervals of home leave, confidence is built up and the

district nurses and local authority staff get to know the patient and his problems. Thus, graduated discharge smooths the transition from hospital to home; it is of course less practicable if the home is more than 100 miles or so from the hospital.

After the final discharge home visits are made by the follow-up nurse, where necessary, every few weeks. During the past five years 1195 home visits have been made. Since having a home visiting service all members of the spinal unit staff have become more aware of the domestic background and take a less 'hemi-anopic' view of the patient.

To get down to detail and to consider the concrete and the hardware, we have a few minutes to discuss a few of the items which have been found valuable in bringing about a 'soft landing' for the patient at home.

Lifts. Of course many of the disabled are, quite rightly, rehoused in more suitable houses or bungalows but this is often an impossibly heavy expense. Furthermore, it may be unpopular with the patient and his family; the Englishman's home should still be his castle even when he is disabled. To recommend the rehousing of a disabled person is a grave step to take as it may sometimes amount to a 'social amputation' with separation from old friends and neighbours. Perhaps we do not make enough use of lifts in this country and we dismiss the idea at once believing them to be complex and unimaginably costly.

There are simple, cheap and easily installed lifts that are hand operated and yet they can be used by many tetraplegic patients who have lost some of their upper limb strength. By means of a counter-weight and using the principle of energy storage there is no need to be strong or strenuous to operate this lift. It can be installed in a day and costs about £300, including installation costs.

Turning Beds. Heavily disabled tetraplegics with sensory loss will do better at home when provided with an electrically operated turning bed and a hoist. We have found the continuous motion *Co Ro* bed particularly valuable and several of our heavyweight high tetraplegics owe their return home (to the care of ageing parents in several cases) to the provision of this bed by the local authority. It is obviously more easy to obtain this bed—it costs about £600—in cases when there is a well-based compensation claim and in such circumstances the social services will allow an interest-free loan. It is, of course, possible for the bed to be controlled by the patient when necessary by a puff and suck tube actuating the switches.

Hoists are not very attractive devices and there is something too unsubtle about them as they seem to emphasise more than they circumvent the patient's disability; they are, however, indispensable in heavy cases. There is much to be said for simplicity and at Oswestry we prefer a fairly cheap one which easily goes into the boot of a car. This hoist is useful in restricted space and can also be used to transfer a patient into a car seat.

Standing Frame. Patients who do not succeed in attaining useful walking in calipers or leg braces while in hospital are encouraged to use a standing frame. Frequently we send a patient home with a standing frame provided by the hospital. The cost is about half the price of long calipers. This apparatus is valuable in diminishing spasm and in maintaining full range of hip, knee and ankle movement. It is also useful to those who work at a bench and is used by two of our school teacher, ex-patients, as a desk.

Bed and Mattress. Some of our paraplegic and tetraplegic patients have been seen at home using thin flock mattresses. A six or seven-inch foam mattress is

more suitable and best used on a special low hospital-type bed—easily available and quite cheap—so that the top of the bed is level with the wheelchair seat.

There is general consensus about the ideal bathroom and W.C. arrangements but it is surprising how often doors are hinged wrongly so occupying valuable bathroom space. We have found showers disappointing and the low suite bath, 24 inches high, is preferred by most paraplegics.

Electrical. These are just a few of the items which can make life easier at home for the spinal injury patient. Much can be done too by more sophisticated and made-to-measure electrical wiring and by the siting of switches and plug points. One sometimes sees the living-room of a disabled person so cluttered up with aids, plugs, wires and general tack that there is a bewildering disorder and discomfort. Patients who have been equipped with a Possum apparatus have found its application to the telephone the greatest boon. Many tetraplegic patients have sufficient residual wrist or finger power to operate light-weight switches placed within easy reach of the wheelchair—so as to provide control of light, heat, radio, T.V. etc.

The application of ergonomic principles in the home has got off to a late start in many countries; the application of such principles to the disabled is also still in a backward state. The ergonomics of the disabled at home is a legitimate and important study for the spinal injury doctor and nurse.