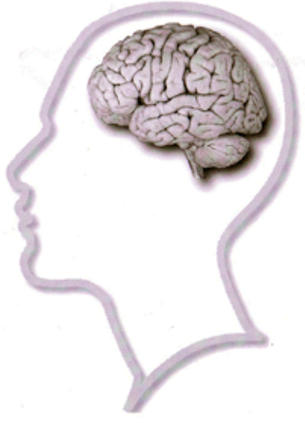
Centre universitaire de santé McGill | McGill University Health Centre

Traumatic Brain Injury Program (TBI)

Discharge Information



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The M.G.H. is an acute care hospital which means that a patient's stay is short-term.

The following information outlines *discharge possibilities* after hospitalisation for a traumatic brain injury (TBI). These options discuss the patient's return *home* or transfer to a *rehabilitation centre* or to a *long-term care facility* or to the patient's *original referring hospital* or to another hospital designated by the *regional health board*.

Please note: As per Ministry of Health regulations the acute care status of the patient is automatically changed to chronic care status on day 45 of his admission unless the treating physician requires to maintain acute care status in writing. When the patient's care is designated as chronic, a financial contribution to housing fees is applied. For further information please refer to the T.B.I. program social worker.

I. DISCHARGE TO HOME

The TBI specialists will discuss with you the possibility of your direct return home if you are:

- Medically stable, which means that the **risk** of needing *medical or surgical emergency care* has passed;
- Not in need of *in-patient* rehabilitation, but able to go to follow-up as an out-patient;
- Adequately cared for at home by family and community services when necessary.

A. FOLLOW-UP

At the time of your discharge home, you will need to continue with follow-up care:

- You should inform your regular family doctor of your TBI accident as soon as possible.
- If necessary, you will receive a follow-up appointment in one of the MGH Clinics.
- If necessary, you will be referred as an out-patient to make regular visits from your home to a rehabilitation centre.

If you experience **urgent concerns** before you can be seen at these appointments, please contact your family doctor or come to the *Emergency Room(preferably of the MGH)* or of the closest hospital.

Urgent concerns include having a ***new*** or a ***worsening condition*** of one or more of the following symptoms:

- progressive drowsiness
- confusion
- vomiting more than 3 times
- continuous headache not relieved by analgesics (acetaminophen and codeine)
- drainage of fluid or blood from ears or nose
- seizures or epilepsy
- blurred or double vision
- difficulty with speech
- weakness in an arm or a leg

B. COMMUNITY SERVICES

Our health-care system relies on the families and close friends of TBI patients to take their share of responsibility for your convalescent care at home.

If it is assessed that you require special aids, homemaking services, Meals-on-Wheels or home nursing care, these can be arranged for you through your local CLSC. Please keep in mind that CLSC services are prioritized, do not always begin immediately upon request and may include fees for non medical help in the home.

Accredited private agencies provide immediate home nursing care and homemaking services for a fee.

The TBI social workers can help you apply for a wide variety of community services such as adaptive transportation, victim compensation, support groups or respite care, if appropriate.

II. TRANSFER TO A REHABILITATION HOSPITAL

The TBI specialists will discuss with you the option of transferring you to a rehabilitation hospital if you are a TBI patient who is:

- Medically stable but still showing signs of COGNITIVE difficulty (memory, thinking, judgement), *and/or* PHYSICAL difficulty (walking, moving around, performing daily activities) *and/or* BEHAVIOURAL difficulty (control of your behaviours or emotions);
- Assessed by TBI specialists to have the potential for recovery and learning;
- Able to undergo intensive therapy which means a demanding program of rehabilitation activities.

The goals of rehabilitation are as follows:

- To reduce the limitations you may have suffered as a result of a TBI;
- To increase your chances to recover from your injuries and to adapt to any long-term difficulty or permanent disabilities;
- To provide technical aids, as well as to teach new ways of thinking, remembering and getting around when a TBI has interfered with your usual way of doing things;
- To improve your ability to care for yourself, communicate with others and return to the most independent lifestyle in your community that is possible;
- To help your family and friends adjust to the changes since your TBI.

Some rehabilitation centres offer specialised programs for TBI patients with ***significant*** cognitive and/or behavioural problems. Patients without ***significant*** difficulty with these problems may be referred to rehabilitation facilities with programs focused mainly on recovery from difficulties in walking, moving around and daily activities.

III. TRANSFER TO A LONG-TERM CARE FACILITY

The TBI specialists will discuss with the family (and/or friends if appropriate) of the TBI patient the necessity of transfering the patient to a long-term care facility if the TBI patient is:

- Suffering from **severe and probably permanent** cognitive, physical, and/or behavioural disabilities;
- Medically stable but **can no longer benefit from active rehabilitation**;
- Dependent for daily activities and requires supervised professional care in a structured environment.

Transfer to a long-term care facility:

- The social worker helps assess the needs and resources of the patient and the family;
- Placement in a private facility is more costly but generally has immediate admission;
- Placement in a public facility is less costly but generally has a long waiting period;
- Public placement requires a medical and a psychosocial application form (CTMSP), which are completed by the TBI specialists and the family and sent to the Regional Health Board, which selects the care facility.
- At the long-term facility the patient receives ongoing medical and nursing care. If the patient shows significant improvement, rehabilitation may be reconsidered.

IV. TRANSFER TO A TRANSITION HOSPITAL

While **awaiting an admission** to a rehabilitation or long-term care facility, a **patient may be transferred from the MGH** to a **transition bed** at the patient's original hospital or another hospital designated by the **Regional Health Board**.