Abstract
Posterior Fossa Syndrome (PFS) is a constellation of neurological, behavioural and psychological symptoms occurring in pediatric patients following surgical resection of posterior fossa brain tumours. The clinical presentation of PFS typically includes cerebellar mutism, bulbar dysfunction, ataxia, cranial nerve palsies, flaccid hemiparesis and emotional lability. The intent of this paper is to (a) provide an overview of PFS, (b) explore the case of a 16-year-old adolescent who presented with PFS following surgical resection of a fourth ventricle medulloblastoma, (c) reveal the complexity of her discharge, and (d) describe a discharge management framework used by the authors to guide the discharge process from a general pediatric unit in a tertiary care hospital.

Multiple theories have been proposed as to the etiology and pathogenesis of PFS, yet it remains poorly understood. In addition, questions remain as to why it is observed mostly in children and rarely in adults. There is controversy regarding whether tumour type, midline location, involvement of the fourth ventricle with brainstem invasion, and verminal incision are risk factors for developing PFS. Extensive vermis injury and fourth ventricle involvement have been associated with cognitive, mood and behavioural problems (Doxey et al., 1999; Siffert et al., 2000; Turkel et al., 2004; Van Calenbergh et al., 2006; Wolfe-Christensen et al., 2007).

A review of Posterior Fossa Syndrome
PFS was first described in the mid-1980s as transient mutism and speech disturbances without the loss of consciousness and without any symptoms of aphasia in pediatric patients following surgical removal of tumours located in the posterior fossa (Rekate et al., 1985; Yonematsu, 1985). Since then, there have been numerous case reports and retrospective reviews contributing to new knowledge of PFS. In the last decade, there are studies identifying neuromotor speech patterns, behavioural dysregulation and cognitive impairment in patients with PFS. Visual disturbances and bowel and bladder dysfunction have also been reported (Daniels, Moores, & DiFazio, 2005; De Smet et al., 2007; Kirk, Howard, & Scott, 1995; Robertson et al., 2006; Siffert et al., 2000; Turkel et al., 2004; Wolfe-Christensen et al., 2007).

Planification du congé d’une adolescente souffrant d’un syndrome de la fosse postérieure
Une histoire de cas
Le syndrome de la fosse postérieure (SFP) est une combinaison de symptômes neurologiques, comportementaux et psychologiques présents chez les patients pédiatriques à la suite de résection d’une tumeur cérébrale de la fosse postérieure. Les composantes cliniques du SFP comprennent : un mutisme cérébelleux, une perturbation des fonctions du bulbe rachidien, de l’ataxie, une paralysie des nerfs crâniens, une hémiplegie complète et une instabilité émotionnelle. Le but de cette présentation est de : (a) définir le SFP ; (b) réviser l’histoire de cas d’une adolescente de seize ans ayant le SFP à la suite d’une chirurgie cérébrale pour résection d’un médulloblastome situé dans le quatrième ventricule de la fosse postérieure ; (c) démontrer la complexité de la planification du congé de la patiente ; (d) décrire le plan d’action utilisé par les auteurs pour faciliter le processus de préparation du congé des patients de pédiatrie dans une hôpital de niveau tertiaire.
Despite this controversy and the contradictions regarding etiology, pathogenesis and risk factors, there is universal agreement that the hallmark symptom of posterior fossa syndrome is delayed-onset cerebellar mutism. Immediately postoperatively, speech is preserved with a latency period of zero to seven days before the onset of mutism (Doxey et al., 1999; Siffert et al., 2000; Türkel et al., 2004; Van Calenbergh et al., 2006; Wolfe-Christensen et al., 2007). The period of mutism has been reported to persist from four days to 52 weeks (Robertson et al., 2006; Siffert et al., 2000; Türkel et al., 2004; Wang et al., 2006). Recovery of speech is said to occur when the patient begins to verbalize single words. Resumed speech is typically hoarse, hypernasal, and dysarthric with a classic cerebellar scanning quality.

Earlier reports propose that mutism is transient and patients are expected to fully recover normal speech (Al-Jarallah et al., 1994; van Mourik et al., 1997). There is emerging evidence that recovery of speech is less favourable than previously ascertained and that speech is unlikely to return to baseline (De Smet et al., 2007; Huber et al., 2007; Huber et al., 2006; Robertson et al., 2006). Huber et al. (2007) propose that neuromotor speech deficits are more severe in patients with radiated medulloblastoma and that dysfluency, not previously reported, is a part of the motor speech disorder of PFS.

Symptoms of emotional lability, apathy, irritability, and decreased initiation and motivation are also clinical features of PFS (Türkel et al., 2004; Wolfe-Christensen et al., 2007). Wolfe-Christensen et al. (2007) suggest that patients with PFS following medulloblastoma resection are more likely to experience internalizing symptoms, withdrawal, perfectionist behaviours and somatic complaints. Levisohn, Cronin-Golomb and Schmahmann (2000) evaluated the neuropsychological data in 19 children, age three to 14 years, who underwent surgical resection of cerebellar tumours (medulloblastoma, astrocytoma, ependymoma) without radiation or methotrexate chemotherapy. Results indicate that children with PFS had impairments in the areas of behavioural and emotional regulation, visual-spatial function, language, sequencing and memory (Levisohn et al., 2000).

Interestingly, swallowing function is inconsistently reported to be affected in patients with PFS. There is a paucity of data describing swallowing difficulties and recovery patterns (Al-Jarallah et al., 1994; Dailey et al., 1995; Rekate et al., 1985, van Mourik et al., 1997). Studies are typically reported in case study format, often done retrospectively, with limited or unspecified assessment parameters and timeframes. Rekate et al. (1985), Al-Jarallah et al. (1994) and Dailey et al. (1995) all report intact gag and cough mechanisms and normal oral-motor movements, but only Dailey goes on to make note of swallowing coordination difficulties despite the normal oral-motor movements. More detailed movement analysis was reported by van Mourik et al. (1997) who studied the simple and complex orofacial movements in five patients with PFS during the period of mutism and shortly after speech returned. Their results indicated that swallowing problems, if present, resolved early in the mute period, yet movements of swallowing could not be executed on request.

Case study

Louise* is a 16-year-old girl who presented to hospital in 2007 with a diagnosis of obstructive hydrocephalus. Six weeks earlier, Louise had complained of abdominal pain, nausea and vomiting. Over the next month, she experienced additional symptoms of bi-frontal headache, dizziness, leg weakness and progressive unsteadiness. She was cachexic from frequent vomiting and a reported weight loss of 9 kilograms. Louise was admitted to her local hospital with a diagnosis of mononucleosis and remained hospitalized for four days. Her symptoms did not abate by the time of discharge.

Louise returned to her local hospital nine days following discharge with severe headache, lethargy, retching, slurred speech and ataxia. Fundoscopy identified bilateral papilledema. A Computed Tomography (CT) of her brain revealed enlarged ventricles and a solid cystic mass in the area of the fourth ventricle. The patient was transferred to our hospital where an urgent Magnetic Resonance Imaging (MRI) scan demonstrated a posterior fossa mass arising from the cerebellar vermis. The mass was heterogeneous with solid and cystic components. There was marked hydrocephalus with downward displacement of the floor of the third ventricle, cerebellar tonsils and inferior brainstem with effacement of the basal cisterns. The provisional diagnosis, based on the MRI findings, was a medulloblastoma or ependymoma.

Course in hospital

Once admitted, Louise was immediately started on dexamethasone and her vomiting improved significantly. An enteral feeding tube was inserted to optimize nutrition. Twelve days later, she underwent a suboccipital craniectomy and C1 laminectomy for gross total resection of the tumour. An extra-ventricular drain (EVD) was placed intraoperatively as the intraoperative course was complicated by prolonged periods of bleeding and cerebral edema.

Louise’s early postoperative recovery was complicated by persistently elevated increased intracranial pressure requiring prolonged intubation, several days of hyperosmolar therapy and repeated opening of the EVD. Upon extubation on the seventh postoperative day, the patient spoke softly, using single words. By this time, she had developed a left cranial nerve VI palsy, diplopia, and nystagmus. On motor exam, she presented with a profound lack of volitional movement and hypotonia. She developed significant axial and appendicular ataxia. Physical examination noted a right facial palsy and dysphagia with increased drooling. Examination of her vocal cords revealed normal movement and mobility. Twelve days postoperatively the patient experienced cerebellar mutism lasting a total of 22 days.

Due to persistent hydrocephalus, the patient returned to the operating room two-and-a-half weeks later for insertion of a ventriculoperitoneal shunt (VP) and removal of the extra-ventricular drain. A central venous catheter was inserted for chemotherapy and long-term venous access. The final tumour pathology was consistent with medulloblastoma.

Pediatric patients with non-disseminated medulloblastoma with complete or near complete surgical resection and negative postoperative lumbar puncture CSF cytology are consid-
ered to be Standard Risk according to the Children's Oncology Group. Children with Standard Risk medulloblastoma have an expected five-year survival of 65% to 80% (Canadian Oncology Group, 2008).

Louise was entered into the COG Standard Risk Medulloblastoma protocol and began treatment four weeks following surgery when her incisions had healed. Induction consisted of conformal craniospinal irradiation including posterior fossa irradiation over a period of six weeks with adjuvant weekly Vincristine chemotherapy (COG, 2008). During these six weeks, Louise experienced fatigue, headache, nausea, vomiting, and mucositis. She was put on a bowel routine to prevent constipation, a common side effect of Vincristine therapy.

Social background
A primary focus for pediatric nurses is recognizing the impact of the patient's emotional and developmental needs on acute and chronic illness. The uniqueness of pediatric nursing is learning the patient's and family's story. Prior to her illness, Louise lived with her parents and 12-year-old brother in a community two hours' driving distance from our institution. She spoke of a large network of friends and proudly pointed to the many photos posted in her hospital room. As an adolescent, the patient balanced school and family obligations with household responsibilities and social activities. She was a sports enthusiast. Louise was enrolled in a regular curriculum at high school, however, required periodic classroom and home tutoring support.

Louise's parents worked full-time outside of the home with the father working shift work. Her mother held the only driver's licence in the family. The parents describe a close relationship with extended family members living in their community. As a family, they share a passion for hockey and attended Louise's brother's games throughout the hockey season. During Louise's extended hospitalization, her mother assumed the role of primary caregiver and communicator with the health care team. Her father visited on his days off and her brother visited regularly. Following the surgery, Louise's main goal was to return home to be reunited with her family. She deferred the majority of decision-making to her parents.

Hospital rehabilitation
Dysphagia and mutism
The speech-language pathologist (SLP) assessed Louise for both swallowing and speech difficulties. Following extubation, the patient exhibited weak and infrequent swallowing of saliva with excessive drooling requiring frequent suctioning. Verbal instruction was necessary to elicit basic mouth movements of jaw opening and closing, tongue protrusion and tongue retraction. To prevent episodes of aspiration pneumonia, Louise remained NPO and received enteral feeds via a nasogastric tube.

As the drooling improved and Louise was able to manage her secretions, the therapists assessed her to be safe for oral feeding trials. However, Louise continued to experience vomiting, which, with her dysphagia, contributed to her fears of choking. She was especially hesitant to do any eating or drinking. For several weeks, Louise allowed only the therapists to feed her minimal amounts, limiting her oral diet to mainly bites and sips. Due to dysphagia and ongoing hesitancy to pursue oral feeding, a gastrostomy tube (GT) was inserted upon completion of induction chemotherapy and radiation.

The return of speech began with spontaneous single words and progressed to short phrases within a couple of days. Louise's speech was effortful due to ongoing oral motor dyspraxia. Louise rarely initiated speech and relied on non-verbal gestures such as facial grimacing or smiling. When asked direct questions, Louise looked to her mother to answer for her, or she waited for the speaker to rephrase the question to which she could answer by head nod or shake to agree or disagree. She did not verbally respond to questions or express ideas. Gradually over the next two months, Louise began initiating and responding using single words with occasional short sentences. Her speech was imprecise and slow, characterized by pauses and interruptions but, for the most part, was intelligible to familiar listeners.

Emotional lability
During the period of mutism, Louise appeared cheery, agreeable and receptive to all nursing and therapy interventions. With the return of speech, however, Louise experienced sudden onset of emotional lability in which she cried frequently and spontaneously. It was a significant challenge for nurses to engage or motivate her to participate in any aspect of self-care. The patient's lack of motivation was also stressful for her parents who expressed ambivalence and reluctance to set expectations with Louise, given her emotional distress. The psychologist met regularly with Louise and her parents to work through the enormity of issues related to this life-changing event and assist them to develop coping strategies. The psychologist supported the parents to set expectations during the challenging period of Louise's emotional lability and met individuallly with Louise to address the magnitude of her losses as an adolescent.

Activities of daily living
Louise was dependent for all self-care tasks and activities of daily living (ADL). Mobility and balance were challenged by her tall stature, flaccid tone and global ataxia. Louise was deconditioned and demonstrated poor endurance. Occupational therapy sessions consisted of energy conservation strategies, assistive device options and ADL retraining activities. Physiotherapy goals focused on improving her strength, mobility and coordination along with sitting tolerance in her wheelchair. An important nursing priority was to establish a routine and expectations to promote bowel and bladder continence and to maintain skin integrity. Therapies and nursing care were scheduled around daily radiation appointments and were spaced during the day to provide rest periods.

Discharge management
For adolescents living in southwestern Ontario, there are three publicly funded options for neurorehabilitation upon discharge from our tertiary care centre. The first option is an intensive residential acquired brain injury (ABI) program for adults. This program is located close to our institution allowing for continuity of Louise's oncology care, but requiring the family to continue daily travelling. The second option is an intensive pediatric
residential ABI program located in a city further away from the family home, making daily travelling time approximately three to four hours. This option not only created barriers to family visitation, but meant Louise’s oncology care would need to be transferred to a different pediatric cancer centre. The third option was to return home with a less intensive, community-based rehabilitation program. Louise and her parents chose the third option, as their priority was to be reunited as a family. Louise looked forward to sleeping in her own room and returning to her community of extended family and friends.

With home as the discharge destination, the health care team needed to develop a comprehensive plan that facilitated coordination of multidisciplinary team activities, prepare the parents to acquire the knowledge and skills necessary to care for Louise, and engage community providers. Six weeks prior to the target discharge date, discharge care conferences were held weekly with the parents, hospital staff and community providers. This facilitated parental involvement from the onset of planning and strengthened communication and collaboration between parents and the multidisciplinary team. This collaboration enabled the parents and team members to discuss mutually agreed-upon goals for discharge (McClain & Bury, 1998; Katz Leurer, Be’eri, & Zilbershtein, 2006; Kertoy, 2004; McClain & Bury, 1998; Murphy, 2001; Simson Nelson, & Lewis, 2000; Stephens, 2005; Sullivan-Bolyai et al., 2004). To our knowledge, there are no published reports examining the specific discharge needs of adolescents with PFS. A framework was necessary to guide the discharge process, particularly in view of the complexity of Louise’s case, the large size of her core team and the limited human and financial resources available for a community-based neurorehabilitation program. The ABI team developed a framework using the existing literature and adapted it to the needs of the pediatric neuroscience patient.

Our framework incorporates Shelton and Stepanek’s (1994) family-centred care themes of a) family/professional collaboration, b) the exchange of information between families and professionals, c) respect for cultural diversity and individuality of each family, d) flexibility and individuality of discharge planning, and e) an appreciation that each member of the family and the family unit has a life beyond the walls of the hospital system. The framework incorporates the elements of patient readiness, family readiness, community and environment in the discharge management process. It addresses patient needs related to equipment and technology, and documentation (Figure 1). The patient and family are central to the framework and to whom all care is directed. Each element has specific criteria that, when met, facilitate a safe and seamless discharge from hospital to home. Examples of selected criteria for each element are found in Table 1. These elements are similar to headings published in other works (Bakewell-Sachs et al., 2000; Kertoy, 2004; Kirk & Glendinning, 2004; Jackson et al., 2002; Simson Nelson & Lewis, 2000).

**Patient readiness**

Patient readiness occurs when the patient is medically, surgically and emotionally stable to be discharged from the hospital. Louise was medically and surgically stable for several weeks prior to her discharge. Emotionally, the patient remained labile and there was dissonance in what she expressed and how she behaved. For example, she spoke about her goal of achieving more independence, yet continually requested that her mother be present and attend to all her needs. It was the opinion of her parents and the health care team that her emotional lability would not improve with a longer hospital stay.

The patient’s mobility deficits were a primary concern for discharge as she was a one-two person transfer in the hospital. Ataxia and hypotonia predisposed her to falls and injury. Louise needed to demonstrate competence in her ability to safely manage transfers with the assistance of only one person. Louise’s mother took her daughter to a local shopping mall on several occasions prior to her actual discharge date to practise transfers in and out the family vehicle.

**Family readiness**

The multidisciplinary team assesses the family’s strengths and their needs to independently manage the patient’s care needs at home (Simson Nelson, & Lewis, 2000; Sullivan-Bolyai et al., 2004). As the discharge process evolved, Louise’s mother identified that she would be the primary caregiver and took a leave of absence from her full-time employment while her husband returned to work. The loss of income, frequent visits of commu-
nity providers and feeling tethered to the family home are risk factors for families, such as Louise’s, to experience social isolation, emotional stress, lack of privacy and financial loss, as described in the literature (Kertoy, 2004; Kirk & Glendinning, 2004; Murphy, 2001).

Louise’s parents expressed their own fears about the uncertainty of Louise’s survival, her ability to cope with cancer treatments and the long-term outcome of PFS. They were concerned about the practical aspects of caregiving and how to balance family priorities. The parents recognized that they needed to set expectations for Louise. They requested direction from the health care team as to how best to support Louise physically, emotionally and behaviourally in her present state.

Preparing Louise’s parents to assume her primary care afforded the patient’s clinical nurses several teaching opportunities. Nurses embraced their coaching role in teaching and evaluating the parents’ abilities to problem-solve and make decisions with respect to enteral feeding, administering medications, changing gastrostomy and central venous line dressings, and maintaining skin integrity. Louise’s nurses established a daily routine of all her personal care activities and provided ongoing supervision and guidance related to mobility and toileting. A home schedule was developed to provide an infrastructure for personal and medical care needs in the first few days after discharge. The health care team engaged Louise’s parents in trouble-shooting and problem solving in anticipating variances to the plan.

At our institution, we embrace a ‘staged’ or ‘graduated’ discharge as a mechanism to support patients and their parents in decision-making, problem solving and confidence in returning home. In the first stage of discharge, parents direct and participate in all aspects of care for a minimum of a 24-hour period. Nursing staff is available for reassurance and in the event of an emergency. In the second stage, day passes ranging from two to eight hours are granted. Taking the child home on a combined day and overnight pass constitutes the third and final stage of the graduated discharge process. The overnight stay usually occurs the weekend prior to the discharge date. We aim for final discharges early in the week and avoid discharges on weekends when resources are less likely to be available.

**Environmental readiness**

Preparing a safe physical home environment prior to Louise’s actual discharge was an early and essential priority of discharge management. Hospital and community-based staff

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<th>Table 1. Criteria of discharge management framework for complex pediatric patients</th>
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<td><strong>Elements of Framework</strong></td>
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| **Patient Readiness** | • The patient is medically, surgically and emotionally stable  
• The mode of nutrition is well established  
• The method of mobility is well established |
| **Family Readiness** | • The family demonstrates a willingness and commitment to assume the primary care of the patient  
• The family acquires new knowledge and skills related to therapy routines, the patient’s equipment and technology  
• A graduated discharge occurs prior to discharge (day/overnight passes) |
| **Environmental Readiness** | • A tentative patient schedule is completed prior to discharge  
• A home assessment determines wheelchair accessibility, structural safety  
• A home assessment identifies the need and makes recommendations for additional equipment or technology to support the patient’s ADLs  
• Referral to Seating & Mobility services for ongoing wheelchair support is completed  
• Home modifications are completed |
| **Equipment & Technology** | • Order specialized equipment and technology  
• Funding options are explored and applications completed prior to patient’s discharge home  
• Local medical supply companies are contacted prior to discharge  
• Delivery of equipment is arranged |
| **Community Readiness** | • A primary community pediatrician/physician is identified  
• A community case manager is identified  
• Referrals to community nurses, therapists, and allied health professionals are completed  
• Referrals to Children’s Treatment/Rehabilitation Centers are completed  
• Respite is explored prior to discharge  
• School liaison established |
| **Documentation** | • A contact list of hospital/community providers is given to parents  
• Set up weekly discharge meetings  
• Minutes of discharge planning meetings are provided to team and parents  
• Patient care plan and therapy reports are shared with community providers  
• Hospital discharge summary is copied to primary community physician and other providers |
worked in partnership to identify challenges and create solutions to barriers in the patient’s physical environment. A home and environmental assessment was completed several weeks prior to the actual discharge date. Such an assessment includes wheelchair and mobility accessibility, storage of enteral feeding supplies, planning for the installation of home adaptations, and recommending assistive devices for toileting and other activities of daily living.

**Equipment and technology**

In Canada, each province has its own funding formulas to support pediatric complex cases (Kertoy, 2004). Yet, parents of children who are technology-dependent frequently incur a financial burden and Louise’s family was no exception. Louise required a custom wheelchair, a porch lift for the front entrance, hospital bed, commode and enteral feeding supplies. A laptop computer modified for augmentative communication was necessary to promote communication and community reintegration, particularly for an adolescent to independently interact with her friends on-line. The parents’ extended health plans offered limited resources required them to fund a portion of the cost of equipment and technology. The health care team explored several options for funding through private and not-for-profit agencies. The parents’ combined income frequently precluded eligibility for additional funding from not-for-profit agencies.

**Community readiness**

Our team engaged the community providers early in the discharge process and requested nursing visits, personal care support, respite, physiotherapy, occupational therapy, speech-language therapy and feeding and swallowing services. Louise required physical therapy and speech-language therapy beyond what was publicly funded. Therefore, we worked with the family to complete applications for private funding to cover the cost of these additional therapies.

A unique consideration for pediatric patients with PFS is returning to school. Louise did not attend in-hospital schooling due to radiation appointments, therapy sessions, fatigue and limited endurance. As part of an eventual return to her home school, a referral to school liaison occurred during the patient’s admission to begin necessary planning and advocacy within the school system. In the interim, home tutoring was requested. As per the oncology program at our institution, Louise would undergo neuropsychological testing at the completion of her 55-week protocol. This assessment would guide the school in implementing learning modifications and accommodations.

**Documentation**

Documentation becomes the paper trail of accountability, decision-making and problem solving in complex discharges. Minutes of discharge care conferences were distributed to Louise’s parents and team members and put in her permanent health record. Prescriptions for equipment, supplies and medications were completed in advance and not left to the day of discharge. Our goal was to arrange for all medication to come from the same pharmacy. We also attempted to contract with as few medical and equipment suppliers as possible to minimize additional work for the patient’s mother when it came time to reorder supplies.

A comprehensive discharge summary detailing the patient’s medical and surgical history, complications, rehabilitation progress and discharge goals was dictated and sent to all team members prior to the patient’s discharge. In the event that Louise presented to the emergency department, the dictation would be a critical information tool for physicians unfamiliar with her care.

**Conclusion**

We presented the case of a 16-year-old female who developed posterior fossa syndrome following surgical resection of a fourth ventricle medulloblastoma. Our team used a discharge management framework to facilitate the complex discharge of this adolescent patient from hospital to home. The case study and framework contribute to neuroscience nursing knowledge by illuminating the complexity of PFS and providing a tangible tool and working document for the discharge management process.

The framework represents preliminary work in addressing the clinical nursing practice aspect of discharge management for complex pediatric neuroscience patients. The framework’s intrinsic feature of family and community engagement paved the way for communication, collaboration and coordination to occur among and across large teams of hospital and community providers. Financial hardship is a significant source of stress for families and one that is of particular importance to neuroscience patients who often require costly equipment and technology. Our experience using this framework emphasized the need to include funding as a separate element with future patients.

The next step in this framework is to evaluate its reliability and validity. It lends itself to an in-depth study of process and outcome measures of each element and the interrelationship to patient/family satisfaction and quality of life. There is also potential for collaborative research among hospital and community providers to use this framework for re-admissions and palliative care of all pediatric neuroscience patients.

Louise was discharged to her home on the planned discharge date at the end of week seven of her protocol. This enabled her to have three weeks at home prior to being admitted for the next, more aggressive phase of the Standard Risk Protocol, which includes nine cycles of maintenance chemotherapy. The two arms of the protocol include Regimen A, which involves administration of Lomustine, Vincristine and Cisplatin on cycles 1, 2, 4, 5, 7 and 8. For Regimen B, cycles of Cyclophoshamide, Mesna and Vincristine are administered on cycles 3, 6 and 9 (COG, 2008).

In reflecting on the discharge process, the parents admitted to feeling apprehensive about assuming all of Louise’s care. They believed the discharge management framework incorporated all of Louise’s needs and assisted them to stay focused on the scope of detail involved in the discharge process. The graduated discharge process enhanced their self-confidence, and assisted them to establish new routines and structure for their family.

*This is a fictitious name to protect patient and family confidentiality.
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References


