

# **National Rehabilitation Hospital**



## **Brain Injury Programme including Stroke Scope of Service**

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## **BRAIN INJURY PROGRAMME (BIP) OF REHABILITATION**

### **SCOPE OF SERVICE**

#### **Introduction:**

The Brain Injury Programme (BIP) of rehabilitation at the National Rehabilitation Hospital (NRH) provides specialised, interdisciplinary, coordinated and outcomes focussed rehabilitation for people with acquired brain injury (ABI).

The continuum of care provided by the programme includes the only national inpatient rehabilitation service for people with ABI in the Republic of Ireland, a comprehensive outpatient assessment and treatment programme and both home and community based and vocational training opportunities. The programme demonstrates the commitment, capabilities and resources to maintain itself as a specialised programme of care for people with ABI.

An Acquired Brain Injury (ABI) is any sudden damage to the brain received during a person's lifetime and not as a result of birth trauma. An ABI may be caused by trauma, tumour, vascular accident (e.g. stroke or subarachnoid haemorrhage), cerebral anoxia, toxic or metabolic insult (e.g. hypoglycaemia), infection (e.g. meningitis, encephalitis) or an inflammatory process (e.g. vasculitis). One of the most important things to know about an acquired brain

injury is that every injury is unique, meaning that symptoms can vary widely according to the extent and locality of the damage to brain tissue. The ensuing impairments can cause a wide range and level of medical, physical, cognitive, communicative, psychological, social, behavioural, vocational, educational, cultural, family, and spiritual and leisure needs in people with ABI. These impairments may also impact the functional abilities of people with ABI to live independently, drive, use public transport, return to work or education, participate in leisure and social activities, fulfil family roles and maintain personal, sexual and family relationships.

Currently, there are no official statistics for the number of people living in Ireland with an acquired brain injury. By studying data from a number of other countries and basing it on the Irish population, it is estimated that between 9,000 and 11,000 people sustain a traumatic brain injury annually in Ireland, with a further 7,000 being diagnosed with a stroke. Additionally, it is estimated that there are up to 30,000 people in living in Ireland between the ages of 16-65 with long term difficulties following acquired brain injury.

Under the direction of the Brain Injury Programme Manager and the Brain Injury Medical Director, the BIP, in conjunction with the persons served and their families/carers, provides individualised, goal-directed rehabilitation designed to lessen the impact of impairment and to assist people with ABI to achieve their desired levels of functional independence, social participation and community reintegration.

The BIP services are provided by an interdisciplinary team through a case-coordinated approach that also addresses:

- Ongoing access to information, referral and transition to services available within the NRH Brain Injury Continuum of care.
- Support for information sharing, movement and access with other external brain injury community resources and stakeholders.
- Provision of education and support to persons served, their families/support systems and the community.
- Facilitation of opportunity for interaction for people with ABI within the NRH Brain Injury Continuum of care

### **NRH Brain Injury Continuum of Care**

The NRH has developed a full continuum of care for people with ABI including Stroke. This continuum includes:



- Brain Injury Comprehensive Integrated Inpatient Rehabilitation Programme (BI/IP)
- Brain Injury Outpatient Rehabilitation Programme (BI/OP)
- Brain Injury Home and Community Based Rehabilitation Programme (BI/HCB)
- Brain Injury Vocational Services (BI/V)
- Brain Injury Stroke Speciality Programme

This comprehensive, interdisciplinary continuum of care ensures that all individuals can receive the most appropriate programme of care based on their injury and their individual rehabilitation needs. Treatment can begin anywhere on this continuum, and persons served can progress through this continuum and to other appropriate community and follow-up services.

In some instances the person served can receive services from multiple NRH programmes and services throughout their continuum of care. For example, a person who has experienced a brain injury may also have a spinal cord or amputation injury. This “dual diagnosis” requires a specialised and individualised treatment plan that addresses the unique needs of the person, and utilises the expertise and close working of multiple NRH programme staff and services.

Families, carers and other members of the person’s support system are all partners in the rehabilitation process. As such, support individuals are encouraged to participate in all aspects of the programme. Information, education, counselling, emotional and psychological support has been demonstrated to reduce the emotional sequelae experienced by the family/carer. This support may help the process of adaptation and coming to terms with life changes, and so result in better long-term outcomes for both the patient and the family. Rehabilitation is a continuous and life long process.

### **Rehabilitation Setting**

The National Rehabilitation Hospital (NRH) is a publicly financed, voluntary, free-standing, 110 bed inpatient and outpatient rehabilitation hospital located in South Dublin suburb of Dun Laoghaire.

# **INPATIENT REHABILITATION**

## **(BI/IP)**

The BI/IP is a 56 bed inpatient brain injury rehabilitation and stroke programme with several sub-specialties/ divisions as below:

Acquired Brain Injury

Stroke Programme

Persistent Disorders of Consciousness (PDOC 3 beds in single rooms),

Neuro-behavioural Unit

Early Access Rehabilitation Unit (EARU – 10 beds).

BI/IP service areas are located throughout the hospital four BIP wards occupy the second and third floor of the hospital. Each ward has a consultant delivered interdisciplinary team, comprising of non-consultant hospital doctors, rehabilitation nursing, physiotherapy, occupational therapy, speech and language therapy, psychology and medical social workers acting as case coordinators. Each of the wards serves patients with mixed complexity levels from low to high. There are also 3 beds that are dedicated to persons with ABI with persistent disorders of consciousness (PDOC) and a specialist neurobehavioural service a. The four BI/IP wards are:

PDOC programme

The programmes have 3 beds designated for patients with persistent disorders of consciousness. These 3 single rooms are located in three wards (St. Brigid's, St. Pat's and St. Gabriel's wards).

EARU

There are 10 designated early access beds currently located in St. Brigid's ward.

The EARU will admit patients of low and moderate dependency referred to the NRH who meet the admission criteria for the Brain Injury Programme. Referrals will usually come from an acute hospital after acute management and stabilisation. The EARU will admit patients with primary disability as a result of an acute stroke, other acquired brain injury or a confirmed diagnosis of a non-progressive neurological condition requiring aftercare and rehabilitation. The anticipated length of stay is 4 - 6 weeks after which, if further rehabilitation is required, patients may be discharged home with community rehabilitation services OR be transferred to a continuing rehabilitation facility.

- St. Patrick's ward. This is a secure 9 bedded ward comprised of 7 individual cubicles and 2 large individual ensuite rooms, one of which is dedicated to the PDOC service. This ward is the primary service for those with neurobehavioural difficulties (3 beds), and as is a secure ward. The ward has individual therapy, interdisciplinary treatment and administration areas, therapy kitchen, pacing area, dining and TV and recreational areas. There is video surveillance of all patient areas.
- St. Brigid's ward. This is a 19 bed ward that includes one large 15 bed ward, 3 single rooms and a single cubicle. One room is designated to the PDOC service.
- St. Camillus' Ward. This is a 15 bed all male ward.
- St. Gabriel's ward is a 13 bedded ward comprised 11 female only beds in the main area and 2 single ensuite rooms. One room is designated to the PDOC service and the other room for special requirements such as infection control. As they are single ensuite rooms they can be used for either gender.

### **Hours of Service**

The BI/IP provides 24-hour, seven-day-a-week medical, rehabilitation and nursing care.

### **Exclusion Criteria:**

Persons with ABI are excluded from the BI/IP where other needs (e.g. medical/psychiatric/behavioural/drug and substance misuse) predominate over the potential to benefit from specialised inpatient rehabilitation care and the cognitive, physical and psycho-social needs of the patient. In these cases recommendations maybe made to the referring agent regarding other more appropriate services at this time.

### **Admission Criteria:**

To be admitted into the BI/IP at the NRH, the individual must:

1. Have one of the following:
  - a. Acquired brain injury or disease (ABI), which is an inclusive category that embraces acute (rapid onset) brain injury of any cause, including:
    - i. Trauma (head or post-surgical injury)

- ii. Vascular accident (stroke or subarachnoid haemorrhage)
  - iii. Cerebral anoxia/hypoxia
  - iv. Toxic or metabolic insult (e.g. hypoglycaemia)
  - v. Infection (e.g. meningitis, encephalitis) or other inflammation (e.g. vasculitis).
  - vi. Non malignant or low grade brain tumour
- b. Have medical, cognitive, physical, communicative and/or behavioural needs related to the acquired brain injury or disease process.
- Be aged 18 or over at admission or in the case of the patient over 65 with stroke be referred by a Geriatric Medicine Specialist.
2. Have identified medical, cognitive, physical, communication and/or behavioural needs which cannot be met in an outpatient, community or home rehabilitation setting.  
Have the potential to benefit from specialised inpatient rehabilitation through the utilisation of an interdisciplinary team approach within a specified time-frame.
  3. Be under the care of a National Rehabilitation Hospital Medical Rehabilitation Consultant.
  4. In some cases, where preadmission assessment of rehabilitation needs has identified that long term placement is likely to be required due to complex or specific needs, then this funding for this long term placement and the location is confirmed prior to the admission to NRH.

Within the NRH resources, NRH BIP is best positioned to provide expert neurorehabilitation to those with acquired brain injury, within NRH competency and expertise. If a Consultant in Rehabilitation Medicine feels a person with another neurological disorder can benefit from this skillset and has identified/ specific identified goals, and other more appropriate services are not available, then they may refer to NRH BIP.

Access to these NRH services on the BI programme may include :-

- Consultation by Consultant in Rehabilitation Medicine
- IDT assessment and recommendation
- Advice from specialist neuro-rehabilitation team on equipment, self – management strategies,



- Recommendation to allied health professional colleagues on treatment programme or other significant agencies
- Onward referrals to other agencies

Admission to the programme is based on the preadmission assessment of need and on meeting the programme's admission criteria. However, the timing of admission to the BI/IP may be influenced by the preadmission assessment of the specificity, intensity of the individual's needs and level of dependency, in relation to BI/IP's capacity to best meet these specific needs at that time.

The brain injury programme operates a waiting list system which is monitored by the waiting list management group to ensure that all administrative, managerial and professional health care staff follow an agreed minimum standard for the management and administration of the NRH brain injury programme in-patient waiting list in adherence to national policy.

### **Discharge Criteria:**

To be discharged from the BI/IP at the NRH, one or more of the following must be true:

1. The person is deemed to have achieved their individual goals and therefore maximum benefit from the inpatient programme.
2. The person has improved to the projected functional level that will allow discharge to another specified environment or service.
3. The person experiences major intervening surgical, medical and/or psychological problems that precludes further benefit from a continuing an intensive inpatient rehabilitation programme.
4. The person's ongoing rehabilitation needs (as assessed by the inpatient team) can best be met in an alternative environment or service. In this case, discharge also involves relevant services being informed and set-up and appropriate care packages arranged.
5. The person is no longer willing to be an active participant in the inpatient programme or chooses to self-discharge.
6. The person is non-compliant or unable to comply with programme services.

The person has the right to make decisions regarding his or her rehabilitative care, and the right to refuse any portion of the programme, up to and including discharge against informed medical advice. Should the person elect to exercise his or her rights, the rehabilitation team will guide the person and the family through the process.

Although each inpatient programme has admission criteria the NRH does not operate a denial of services. In response to any referral there is an assessment of eligibility for the particular service. If no service can be offered advice from a medical rehabilitation perspective is given to the referrer.

### **Services Provided For The Person Served:**

Following appropriate referral to the BI/IP, the person will receive a comprehensive, interdisciplinary preadmission assessment in order to identify their needs. This assessment may include medical, physical, cognitive, communicative, psychological, social, behavioural, vocational, educational, cultural, family, and spiritual and leisure needs. This is also an opportunity for persons referred to receive information about the BI/IP including characteristics of persons served, types of services offered, outcomes and satisfaction from previous patients served, and any other relevant information. Following this assessment and if the person meets the BI/IP admission criteria, they may be offered admission to the BI/IP based on level of dependency and chronological referral.

Following admission to the inpatient programme the interdisciplinary team members, in collaboration with the patient and their family/support network, will develop a comprehensive, goal directed treatment plan that addresses the identified needs of the patient and their family/support network. Persons served and their family/support network are offered appropriate information and opportunity for feedback at every stage of the rehabilitation process, and are actively involved in decisions regarding their care. Persons served and their family/support network are also offered education regarding primary prevention of further ABI and secondary prevention related to better management of potential risks and complications.

Persons admitted to the BI/IP receive a minimum of two hours of direct rehabilitation nursing and therapy services per day Monday through Friday. Direct service intensity differs on weekends depending on resources available and individual needs. Home and/or community leave is also facilitated for persons

served in order to achieve for gradual reintegration for the person into these environments.

**Services offered in the BI/IP to meet identified needs could include:**

- Activities of daily living (ADL) assessment and training
- Adaptive equipment assessment and training
- Assistive technology assessment and training
- Audiology screening
- Behavioural assessment and management
- Bowel and bladder training
- Clinical neuropsychological assessment
- Cognitive rehabilitation training
- Coping with and adjustment to disability support
- Dental Services
- Discharge Planning
- Driving and community transport assessment
- Dysphagia assessment and management
- Family/ support system education, training and counselling
- Hydrotherapy
- Independent living skills assessment & training
- Medical assessment and management
- Mobility assessment and training
- Nutritional counselling and management
- Orthopaedic assessment
- Orthoptics
- Orthotics and splinting assessment and training
- Pastoral and spiritual guidance
- Patient advocacy and support
- Patient education, training and counselling
- Pharmaceutical care, management and training
- Podiatry/Chiropody
- Prosthetic assessment, training and management
- Psychosocial assessment and psychotherapeutic intervention
- Radiology
- Rehabilitation nursing
- Relaxation and Stress Management
- Respiratory therapy
- Safety awareness and training
- Sexuality counselling

- Smoking cessation training and support
- Spasticity management
- Speech/Language and communication assessment and training
- Urology service
- Vocational assessment and counselling

**Ancillary services could include:**

- Advanced assistive technology assessment and prescription
- Medical speciality referral for consultation including Psychiatry , Radiology- Brain Imaging, Orthoptics and Neuro-ophthalmology, Neuro-psychiatry and Orthopaedics
- On road driving assessment and training
- Optician
- Osteoporosis assessment
- Podiatry
- Substance abuse counselling
- Video fluoroscopic swallowing evaluation

If additional services are required and not available on-site at NRH, the BI/IP can facilitate referral to wide range of ancillary and support services.

People with ABI in the BI/IP frequently have complex disabilities and subsequently complex rehabilitation needs which require specialist intervention by professionals with knowledge and experience in the management of acquired brain injury. The composition of the interdisciplinary team for each person served is determined by the assessment of the person's individual medical and rehabilitation needs. These team members could include:

- Brain injury liaison coordinator
- Chaplain
- Clinical neuropsychologist
- Clinical psychologist
- Dietitian
- Discharge liaison occupational therapist (depending on geographical criteria)
- Dysphagia therapist
- Health care assistants
- Hydrotherapist
- Medical Social worker

- Occupational therapist
- Pharmacist
- Physiotherapist
- Psychiatrist
- Radiologist
- Recreation Therapist
- Rehabilitation medicine specialist
- Rehabilitation nurse
- Speech and language therapist
- Sports therapist

The carrying over of new skills gained in treatment into daily activities and into discharge environments is critical to the success of any rehabilitation programme.

### **Services provided for Families, Carers and Support Systems of Person Served:**

Many services are available within the BI/IP to meet the needs of the person served and their family/carers including:

- Education/training about management of ABI related issues (formal education, printed resource material, instruction and practical skills training in preparation for discharge).
- Supported living on site in our short stay transitional independent living facility.
- Psychological support services
- Pastoral and spiritual services
- Peer support through interaction with other families and various community support groups (e.g. Brí, Acquired Brain Injury Ireland and Headway Ireland).
- Information about community support, advocacy, accommodation and assistive technology resources.

### **Discharge Outcomes and Environments**

The BI/IP aims to discharge all person served after they have achieved their desired rehabilitation goals and are deemed to have received maximum benefit from the programme. The BI/IP strives at all times to discharge patients to their most appropriate and desired discharge environment, taking into consideration the person's and families wishes, their clinical and functional status, legal restrictions and availability of community and home supports. The majority of persons are prepared for discharge home.

Alternative discharge destinations such as long-term care facilities, assisted living residences, group homes or post acute rehabilitation programmes may be recommended based on level of functional independence and services available. Discharge to an acute hospital setting may be necessary in the event of medical illness or to await access to local community support services.

### **Palliative Care**

The NRH strives to deliver goal orientated rehabilitation for all patients who require our service. However, it is recognised that in some instances active rehabilitation is not the appropriate or suitable approach for the patient and / or their family. In such cases, the NRH will liaise with all relevant parties to ensure the best possible outcome for all. The NRH will refer to palliative care services where this is medically indicated and in full agreement with the patient and/ or their family. The NRH will support the transition to such services and aim to secure these services in the most suitable location for the patient and/ or their family.

## **OUTPATIENT REHABILITATION**

### **(BI/OP)**

Brain Injury Outpatient rehabilitation (BI/OP) is delivered in a variety of locations throughout the National Rehabilitation Hospital (NRH). The main Outpatient Dept is located on the grounds of the hospital in Unit 6 and houses assessment, therapy, group and multi-use rooms. There is also a Physiotherapy treatment area located in this building, which includes appropriate equipment and treatment cubicles.

#### **Hours of Service**

The BI/OP provides five days-a-week (Monday through Friday), 9am to 5pm medical, rehabilitation and nursing outpatient treatment and care. Some services are available outside these times by pre-arranged appointment.

#### **Exclusion Criteria:**

Persons with ABI are excluded from the BI/OP where other needs (e.g. medical/psychiatric/behavioural/drug and substance misuse), predominate over the potential to benefit from specialised Outpatient rehabilitation care and the cognitive, physical and psycho-social needs of the patient. In these cases recommendations may be made to the referring agent regarding other more appropriate services.

#### **Admission Criteria:**

To be admitted into the BI/OP at the NRH, the individual must:

1. Have one of the following:
  - a. Acquired brain injury (ABI) is an inclusive category that embraces acute (rapid onset) brain injury of any cause, including:
    - i. trauma – due to head injury or post-surgical damage
    - ii. vascular accident (stroke or subarachnoid haemorrhage)
    - iii. cerebral anoxia
    - iv. other toxic or metabolic insult (e.g. hypoglycaemia)
    - v. Infection (e.g. meningitis, encephalitis) or other inflammation (e.g. vasculitis).
    - vi. Non malignant or low grade brain tumour
  - b. Have medical, cognitive, physical, communicative and/or behavioural needs related to the neurological injury or disease process.

2. Be aged 18 to 64 years at time of admission or (in the case of older adults); be referred by a Geriatric Medicine Specialist.
3. Have identified medical, cognitive, physical, communication and/or behavioural needs which cannot be met in an inpatient, community or home rehabilitation setting.
4. Have the potential to benefit from specialised outpatient rehabilitation through the utilisation of a single or multi-disciplinary team approach within a specified time-frame.
5. Be under the care of a National Rehabilitation Hospital Medical Rehabilitation Consultant.
6. Have arranged own transportation to/from the BI/OP.
7. Also meet admission criteria specific to a single or multi-discipline therapy if referred therapy (see appendices for discipline specific scopes of service).

There are individuals with other neurological disorders who benefit from access to specialist neuro-rehabilitation services as part of goal directed referral by an NRH consultant . Access to these NRH services on the BI programme should a) clearly indicate the “specific goal which is being identified and b) the specific outcome expected for the patient referral to NRH OPD. The referral should clearly identify the specific gap in current services which the NRH OPD department is being asked to address within current resources.

Activities provided to such patients may include:

- Consultation by Consultant in Rehabilitation Medicine
- Single Discipline or Interdisciplinary Team assessment
- Advice from specialist neuro-rehabilitation team on equipment, self –management strategies etc.
- Review and identification of specific issues for intervention
- Recommendation to allied health professional colleagues on treatment programme or other significant agencies
- Onward referral to other agencies
- Redirect and recommendations regarding appropriate agencies if needs cannot be met at NRH Brain Injury OPD Department.
- Implementation of treatment program at the NRH ( IP admission, OPD services RTU etc).



Admission to BI/OP is based on the preadmission assessment of level of need and the meeting of the programme's admission criteria. However, priority of admission may be given to patients referred from the NRH Brain Injury Inpatient Programme (BI/OP). Furthermore, the timing of admission to the BI/OP may be influenced by the preadmission assessment of the specificity, intensity of the individual's needs and level of dependency, in relation to BI/OP's capacity to best meet these specific needs at that time.

### **Discharge Criteria:**

To be discharged from the BI/OP at the NRH, one or more of the following must be true:

1. The person is deemed to have received maximum benefit from the Outpatient programme.
2. The person has improved to the projected functional level that will allow discharge to another specified environment or service.
3. The person experiences major intervening surgical, medical and/or psychological problems that precludes further benefit from a continuing outpatient rehabilitation programme.
4. The person's ongoing rehabilitation needs can best be met in an alternative environment or service.
5. The person is no longer willing to be an active participant in the outpatient programme.
6. The person is non-compliant with outpatient programme services.
7. The person has the right to make decisions regarding his or her rehabilitative care, and the right to refuse any portion of the outpatient programme, up to and including discharge against informed medical advice. Should the person elect to exercise his or her rights, the rehabilitation team will guide the person and the family through the process.

### **The Services Provided For The Person Served:**

Following appropriate referral to the BI/OP, the person will receive a preadmission assessment to identify their unique medical, physical, cognitive, communicative, psychosocial, behavioural, vocational, educational, cultural, family, spiritual and leisure/recreational needs. This is also an opportunity for the person referred and their family/carers to receive information about the BI/OP including characteristics of persons served, types of services offered, outcomes

and satisfaction of previous patients served, and any other information. Following this assessment and if the person meets the BI/OP admission criteria, they may be offered treatment by the BI/OP team.

Following admission the relevant BI/OP team member, in collaboration with the patient and their family/support network, will develop a treatment plan that addresses the identified needs of the patient and their family/support network. Patients and their family/support network are offered appropriate information and opportunity for feedback at every stage of the rehabilitation process, and are actively involved in decisions regarding their care.

### **Medical Rehabilitation Clinics:**

Table 1 (below) outlines the wide variety of Consultant led, Multi-disciplinary and Linked clinics available to persons attending BI/OP.

<b>Brain Injury Clinic</b>	
<b>Linked Clinic</b>	

**Table 1: NRH Brain Injury Programme Outpatient Clinics**

<b>Day</b>	<b>Time</b>	<b>Frequency per month</b>	<b>Name of clinic</b>	<b>Consultant / Clinic lead</b>	<b>Clinics arranged by:</b>
Monday	9.00-13.00 14.00-17.30	1 <sup>st</sup> Monday and Tuesday	Neurobehavioural Clinic	Dr. Delargy Dr. O'Driscoll Dr. Simone Carton	OPD Admin team 01 235 5552
Monday	9.00-13.00	4 <sup>th</sup> Monday	Brain Injury Multi disciplinary New	Dr M Delargy	OPD admin team 01 235 5552
Monday	13.30-16.30	2nd Monday	Brain Injury Multi-disciplinary New	Dr. A. Carroll	OPD admin team 01 235 5552
Monday	9.00 - 12.00	Weekly	Brain Injury Consultant Led New & Review	Dr. McElligott	OPD Admin team 01 235 5389
Tuesday	9.30 - 13.00	Weekly	Brain Injury Consultant Led New & Review	Dr J Morgan	OPD admin team 01 235 5552
Tuesday	13.30-16.30	2 <sup>nd</sup> & 4 <sup>th</sup> Tuesday	Brain Injury Consultant Led Review	Dr. A. Carroll	OPD admin team 01235 5274
Tuesday	15.00-16.00	2 <sup>nd</sup> & 4 <sup>th</sup> Tuesday	Paediatric Clinic	Dr. S Finn	Angela Browne 01 235 5331
Wednesday	14.00-16.00	1 <sup>st</sup> Weds of Month	Orthopaedic Clinic	Mr. K. Synnott	OPD admin team 01 236 5277
Thursday	9.00-13.00	1 <sup>st</sup> & 3rd Thurs	Brain Injury Consultant Led New & Review	Dr. M. Delargy	OPD admin team 01 235 5550
Thursday	9.00 – 13.00 14.00 – 17.00	Alt	Orthoptics	Dr. Irene Reid	OPD admin team 01 235 5375
Thursday	13.00-16.00	Two Thursday's per Month	Disabled Drivers Med Board of Appeal	Dr. Cara McDonagh	Carol Leckie 01 235 5279
Friday	9.00-13.00	Weekly	Prosthetic Clinic	Dr. N. Ryall	Mary MacGinty / Margaret Devlin 01 235 5262
Weekly	By appointment	Weekly	Sexual Health Service	Pauline Sheils Clinical Nurse Specialist	Pauline Sheils 01 235 5288

## **Brain Injury – Consultant Led: New (Interdisciplinary) and Review Clinic**

### **Referral Pathway**

Referrals to the Brain Injury Clinic are accepted from Consultant Neurosurgeons and Neurologists in hospitals (predominantly acute) in the Republic of Ireland.

### **Clinic Activity**

The Brain Injury Clinic occurs 4 days per week from 9am to 1.30pm. Persons served are given 1 hour appointment slots (approx. 4 per clinic) and attend accompanied by a significant other, often a family member. Persons are assessed by the Medical Rehabilitation Consultant and other members of the Multidisciplinary team. The Multidisciplinary team includes Medical, Nursing, Speech & Language Therapy, Occupational Therapy and Physiotherapy personnel. Following initial assessment, appropriate referrals are then made to Medical Social Work and Psychology as the need arises. Appropriate referrals may also be made to our Rehabilitative Training Unit. Permission is sought from the person to speak with significant others in attendance for collateral history as required and to assess the needs of the family/carer.

The Brain Injury Review Clinic also occurs 4 days per week from 9.30am – 1pm. It caters for the follow-up rehabilitation needs of persons served and their families/carers, i.e. those who have been discharged from the inpatient Brain Injury Programme (BI/IP) at NRH. NRH inpatients are automatically offered a review appointment for the Outpatients Clinic. The Clinic can accommodate up to 5 persons in one session with each receiving a scheduled half-hour slot and with extra time allocated for persons with more complex needs.

### **Outcomes / Coordination of Services**

The Multidisciplinary team discuss the person's needs and make recommendations for Outpatient treatment at NRH, Outpatient attendance and or treatment at other settings outside of NRH, or that no intervention is needed. Members of the multidisciplinary team communicate directly with their colleagues and counterparts in the Community. If additional services are required and not available on site, the programme facilitates referral to ancillary services detailed in the section on inpatient rehabilitation.

A small number of patients have a recurring need for support and assessment but most persons can be referred on to their General Practitioner after a number of clinic attendances. The General Practitioner is invited to refer the patient back again as the need arises. Persons are often referred to the Rehabilitative Training Unit, Vocational Services, Orthoptic Clinic and other linked clinics (see Table 1).

## **Neurobehavioural Clinic**

The Neurobehavioural Clinic (NBC) at NRH is a specialist multidisciplinary assessment and review clinic catering for persons with complex and challenging behaviour resulting following acquired brain injury. Prior to its establishment in 1999, there was no specialist service focusing on the neurobehavioural and neuropsychiatric consequences of ABI in Ireland. This clinical need was identified by the NRH Brain Injury Service which led to the development of the NBC. The Clinic is led by Dr. Mark Delargy and also present is Consultant Neuropsychiatrist and a Neuropsychologist.

### **Organisation of Neurobehavioural Clinic**

The NBC is located at the Outpatients Department is located on the grounds of the hospital in Unit 6 and houses assessment, therapy, group and multi-use rooms. Unit 6 is the location for the Brain Injury Programme's NBC.

The NBC is held on a monthly basis (it is the first Monday and Tuesday of every month or 2<sup>nd</sup> Monday and Tuesday when there is a Bank Holiday). It usually convenes from 8am until 6pm, commencing with review of health care records and dictation of letters at the end of the clinic.

Patients are usually offered a 1.5 hour appointment for their initial assessment and subsequent meetings are usually 30-60 minutes by attendance at the clinic or by telephone/teleconference. Patients are requested to attend with a significant other, for example a family member or health care professional that can provide collateral information. Prior to seeing the patient, there is an extensive review of their clinical notes, pre-morbid and post ABI history, clinical investigations (neuro-imaging and neuropsychological assessment), and collateral information.

A pre-clinic questionnaire is also completed with patient and significant other, as appropriate in order to identify both the patients and families primary concerns and expectations of the service.

The initial clinic appointment consists of a comprehensive assessment, with the patient and those whom they have agreed to accompany them. This assessment is carried out by the 3 clinicians and includes a detailed examination of the patients premorbid functioning and current, post ABI symptoms.

The clinical review may, as clinically indicated, be divided between the patient and those who accompany them and or include further telephone contact with others who are deemed to have relevant information.

All who attend the clinic will receive the clinical opinion of the team, the diagnosis, proposed treatment suggestions and proposed follow-up schedule. The number of review appointments will be determined by the nature of the patient's difficulties, the complexity of their presentation and their willingness to participate.

Clinic interventions may include the following;

- Development, review and monitoring of behaviour management plans
- Prescription and review of behaviour modifying medications
- Assessment and advice on patterns of challenging behaviour
- Risk assessment/management
- Education regarding challenging behaviour post ABI. Onward referral/liaison with appropriate community agencies/service providers.
- Advice to state agencies where relevant, for example, the Ward of Court Service.

It is very important to note that NBC is a monthly, tertiary referral service for complex challenging behaviour problems that emerge following an ABI. **As a result this service does not have the capacity to provide emergency consultations for crisis related to challenging behaviour or psychiatric symptoms. All referrers are advised to refer the patient to local services in emergency situations in particular where there is a risk of deliberate self-harm and risk of injury to others**

### **NBC Clinic referral criteria**

The patient must have a Brain Injury involving one of the following mechanisms:

1. An Acquired Brain Injury (ABI) involving one of the following diagnostic categories:
  - Brain trauma – due to head injury or post-neurosurgical injury.
  - Cerebrovascular accident (e.g. stroke or subarachnoid haemorrhage)
  - Cerebral anoxia due to cardio-respiratory arrest etc...
  - Other cerebral toxic or metabolic insult (e.g. hypoglycaemia)
  - Cerebral Infection (e.g. meningitis, encephalitis) or other inflammation (e.g. vasculitis).
  - Brain Tumour -Non malignant or low grade malignant
2. Have experienced changes in personality, behaviour and or mood related to the neurological injury or disease process

3. Be aged 18 to 64 years at time of admission or, in the case of older adults, be referred by a Specialist in Older Persons' Medicine. Referrals for adolescents must be generated by the NRH Paediatric service.
4. Have documented behavioural needs which cannot be adequately managed in an inpatient, community or home rehabilitation setting.
5. Have the potential to benefit from specialised Neurobehavioural rehabilitation through a multi-disciplinary team approach.
6. Be under the care of a National Rehabilitation Hospital Consultant in Medical Rehabilitation. Patients referred by NRH Rehabilitation Consultants will remain under the care of the referring consultant for the duration of their NBC programme. Patients referred from external sources, when appropriate, will be accepted by NRH Rehabilitation Consultant who is lead clinician for the NBC.

**Clinic assessment follows review of the referral information which confirms that the criteria for referral have been met. The timing of assessment at the NBC may be influenced by the preadmission triage which seeks to determine the individuals needs, level of impairment and also correlates to the team's capacity to best meet the individual's specific needs at that time.**

#### **NBC Clinical exclusion criteria**

**Persons who are not suitable for referral to the NBC include those:**

1. Patients who do not have an acquired brain injury.
2. Where other needs (e.g. medical/psychiatric/behavioural/drug and substance misuse) predominate over any potential to benefit from the neurobehavioural expertise of the multi-disciplinary clinic. For these referrals recommendations maybe made to the referring agent regarding other more appropriate services. Once such critical needs of the patient have been met, re-referral to the NBC may be appropriate.

**Other exclusion criteria include patients who present with;**

- An active, uncontrolled addiction

#### **Discharge Criteria**

Discharge from NBC will be determined by the following:

8. The person is deemed by the NBC clinicians to have reached the goals agreed at initial consultation.

9. The person has improved to the projected functional level that allows discharge to another specified environment or service or back to the care of the referring Specialist.
10. The person requires other medical, surgical treatments that preclude them from achieving benefit from the NBC.
11. The person requires committal to an in-patient psychiatric service.
12. The person's ongoing rehabilitation needs can be appropriately met in another environment or service.
13. The person is no longer willing to be an active participant in the Neurobehavioural Clinic.
14. The person is non-compliant with the clinic attendances or recommendations.

### **Referral Pathway**

Referrals for NBC must be generated by a medical practitioner and are predominately received from Consultants in Rehabilitation Medicine, Neurosurgeons, Neurologists, Psychiatrists and from General Practitioners. Essential support information for the referral typically comes from a range of clinical therapists, community care workers and the family/carers. Please see Appendix 1 for full details of referral pathway. #

1. Once the referral has been accepted it will be triaged by the NBC lead Clinicians in order to determine the most appropriate care pathway for the individual.
2. An appointment will be offered based on determined level of need, chronological referral and clinic capacity.
3. Prior to initial assessment the individual and their family/carer will be contacted for a pre-clinic questionnaire by the NBC Clinic Nurse when indicated. (see appendix 2)

### **Outcomes/Coordination of Services**

**The Outcome of each individual differs depending on the nature of their difficulties.**

**Individuals attending the NBC can however expect;**

- **Clarification of their neurobehavioural diagnosis**



- **Behaviour management programme**
- **Reduction in presenting symptoms following advice on support strategies and medical management.**
- **Improvement in perception of quality of life for patient, family and/or carers.**

Recommendations including medication management, neuropsychological and behavioural strategies and future therapeutic input requirements are made at the clinic. Clinic letters and reports are composed by the lead clinician and are distributed to inform the referrer and associated care agencies involved with the person on diagnosis, prognosis and recommendations. Medication recommendations are normally coordinated through the General Practitioner or the Referring Specialist. Following NBC review, patients may be referred to a variety of other services, including the Outpatient Brain Injury Therapy Service at NRH, the NRH home & community and/or vocational programmes, local Neuropsychology services including Headway, ABII etc, local Psychiatric services, a Neuroendocrine Clinic and other services as indicated.

## **Outpatient Therapy**

The purpose of the service is to match the needs of the patient with the therapy services available, given that all available support services are in place to provide it.

The service available is a specialised, comprehensive and customised therapeutic program which reflects that of the inpatient service with regards to the brain injury patient.

Brain Injury Outpatient rehabilitation (BI/OP) is delivered in a variety of locations throughout the National Rehabilitation Hospital (NRH). The main Outpatient Dept is located on the grounds of the hospital in Unit 6 and houses assessment, therapy, group and multi-use rooms. There is also a Physiotherapy treatment area located in this building, which includes appropriate equipment and treatment cubicles.

### **Hours of Service:**

The BI/OP medical, nursing, rehabilitation and outpatient treatment and care is provided five days-a-week (Monday through Friday), 8:30am to 5:30pm. Some services are available outside these times by pre-arranged appointment.

### **Admission Criteria:**

To be admitted into the BI/OP at the NRH, the individual must:

- A. Meet the Scope of Service criteria for admission to the BIP with regard to diagnosis and age
- B. Be under the care of a National Rehabilitation Hospital Medical Rehabilitation Consultant.
- C. Have medical, cognitive, physical, communicative and/or behavioural needs related to the neurological injury or disease process which can be met by the OPD Therapy Team.

More specifically;

1. They must also meet admission criteria specific to a single or multi-discipline therapy
2. If the patient is referred for therapy they must meet the discipline specific scope of service requirements. (see appendices for discipline specific scopes of service)

3. Have identified medical, cognitive, physical, communication and/or behavioural needs which cannot be met in an inpatient, community or home rehabilitation setting
4. Have the potential to benefit from specialised outpatient rehabilitation through the utilisation of a single or multi-disciplinary team approach within a specified time-frame.
5. Patients must have arranged their own transportation to and from the BI/OP.

Referrals, once accepted by an NRH consultant, are assessed and triaged at the weekly OPD Triage and Planning Meeting.

All relevant members of the team are involved in the planning of the admission of patients to the OPD Therapy Service. If there is a known risk, that complicates the program and/or puts patients or staff at risk, then it may be deemed necessary for additional assessments and/or safety plans to be put in place.

The timing of admission to the BI/OP may be influenced by the preadmission assessment of the specificity and intensity of the individual's needs and their level of dependency, in relation to BI/OP's capacity to best meet these specific needs at that time.

Priority of admission may be given to patients referred from the NRH Brain Injury Inpatient Programme (BI/OP).

### **Exclusion Criteria:**

- ❖ Patients with ABI are excluded from the BI/OP where the patient's individual circumstances contraindicate their participation in the therapy program at that time.
- ❖ This will be evaluated prior to the admission to the program and may require review. In the event of an episode that jeopardises the safety of the patient and/or staff, the patient will be formally discharged from therapy and a new referral will be required to reinstate the therapy program. This may include medical/psychiatric/behavioural/drug and substance misuse.
- ❖ Patients where the primary diagnosis is not an acquired brain injury e.g. Cerebral Palsy, Down Syndrome, do not fall under the remit of this service.

- ❖ Patients, whose needs cannot be met by the support facilities available within the hospital, will not be offered that therapy at the NRH, e.g. Complex seating, serial casting, and home access visits etc...
- ❖ In patients where cognitive, physical and psycho-social needs predominate over the potential to benefit from specialised Outpatient rehabilitation care, recommendations maybe made to the referring agent regarding other more appropriate services.

### **Outpatient Therapy Service Referral Pathway**

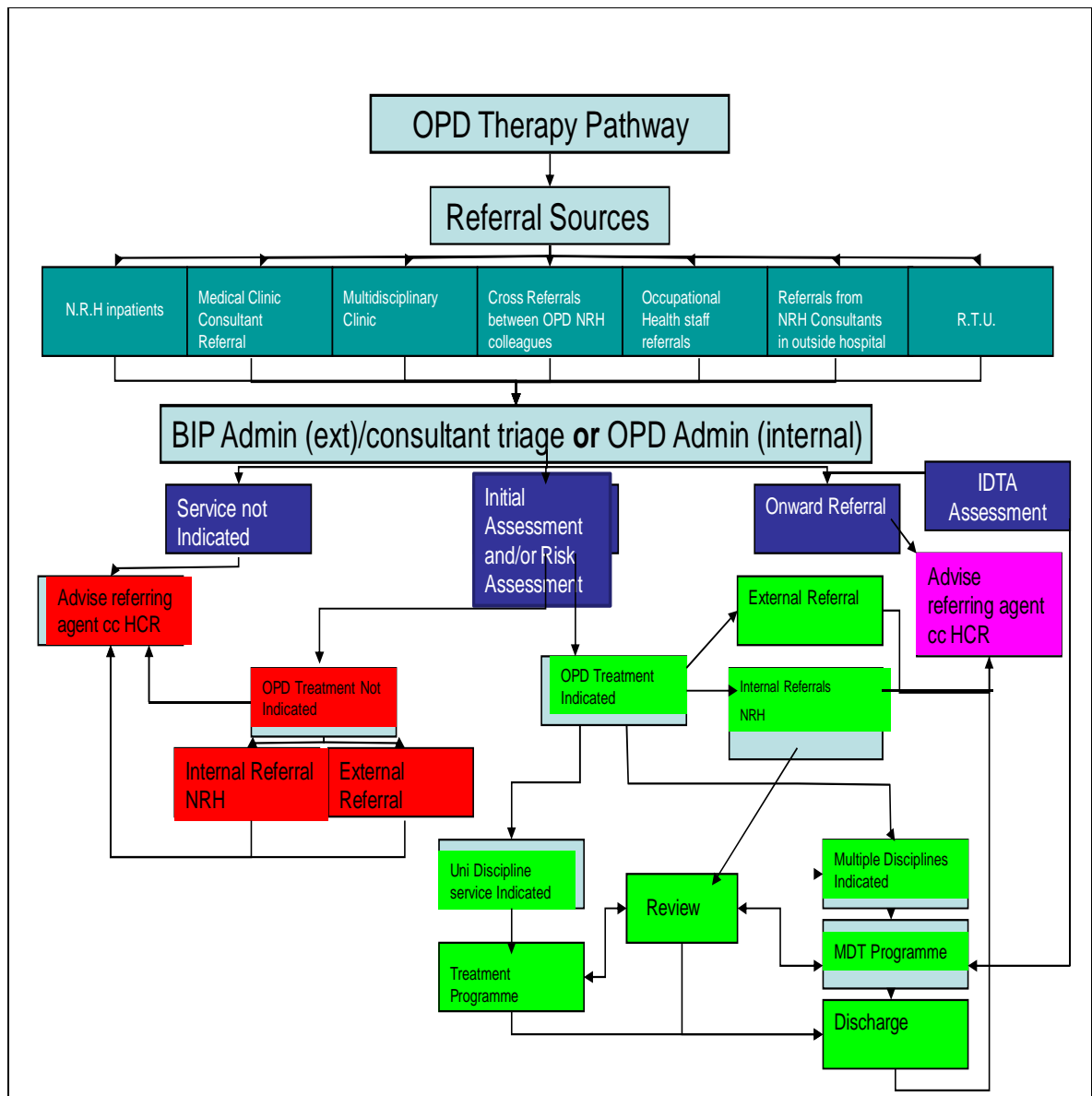
A patient can be referred to The Outpatient Brain Injury Therapy Service at NRH;

1. On completion of their inpatient rehabilitation program.
2. The Brain Injury (New & Review) Clinic for specialist outpatient rehabilitation.
3. Medical Clinic Consultant Referral
4. Cross Referrals between OPD NRH colleagues
5. Occupational Health staff Referrals
6. Referrals from NRH Consultants in/outside hospital
7. R.T.U.

All external referrals to OPD therapy must be sent to the BI Programme using the standard referral form. The referral will be triaged by a consultant within 3 working days.

If the referral is considered appropriate for OPD therapy, the documentation will be sent to OPD for inclusion in the Therapy Triage and Planning Meeting.

Internal referrals to OPD therapy can go via the BI programme or be sent to OPD administration using the standard referral form.



## Therapy Triage

Referrals are checked for minimum data set, logged on PAS, HCR created or requested by OPD administration.

Therapy Triage occurs at the weekly OPD IDT meeting resulting in one of the following options:

- Referral accepted and appointment(s) offered
- Referral accepted and placed on waiting list

- Patient needs specialist/risk assessment
- Case unsuitable

New referrals are scheduled an appointment or placed on a waiting list as indicated and as capacity allows.

The Outpatient Brain Injury Therapy Service includes a wide range of disciplines which are outlined below. The needs of the patient are determined medical and therapy assessment to determine which service the patient needs to access.

Outpatient Brain Injury Therapy members could include:

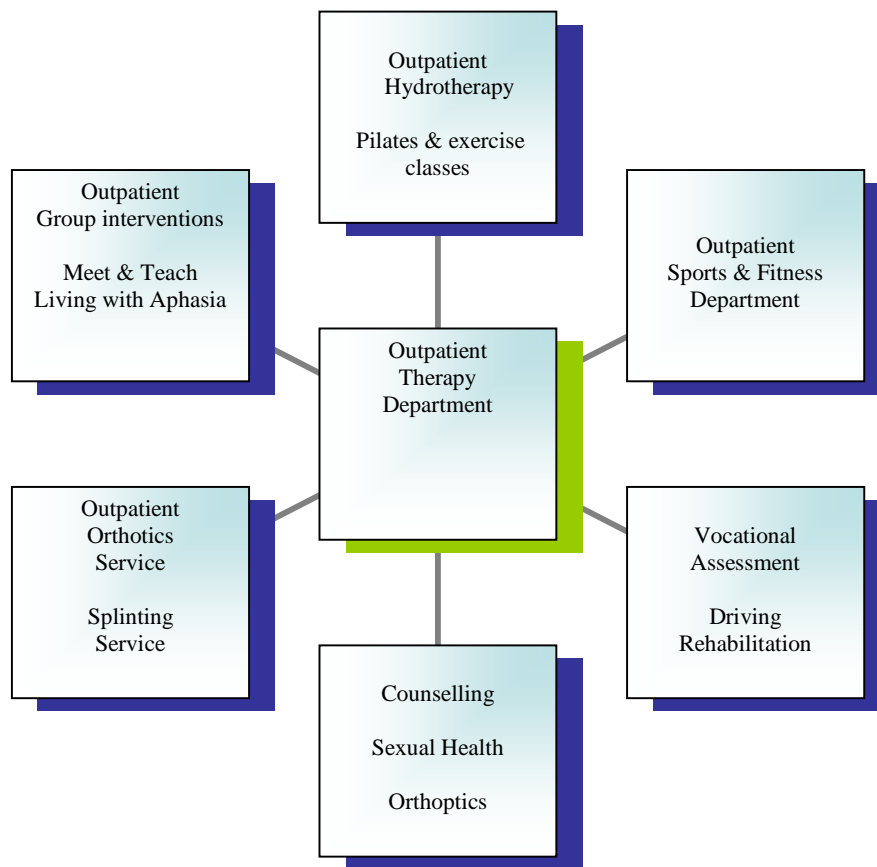
- Clinical neuropsychologist
- Clinical psychologist
- Social worker
- Occupational Therapist
- Physiotherapist
- Rehabilitation medicine specialist
- Rehabilitation nurse
- Speech and Language Therapist
- Rehabilitation Medicine Specialist
- Rehabilitation nurse
- Speech and language therapist

### **Therapy Provision**

Therapy provision to the Outpatient service is provided in three formats:

1. Attendance at **Multidisciplinary Clinics** in an advisory/consultative capacity
2. **Single Discipline** assessment and intervention i.e. therapy sessions provided by an individual therapist for a single patient and/or group of patients
3. **Interdisciplinary** assessment and intervention; i.e. therapy sessions provided with a therapist from another discipline. Interdisciplinary therapy sessions are conducted when therapists are working on shared therapy goals with an individual patient/s.

The OPD Therapy Team also refer onto specialist services within the NRH such as vocational or driving assessments if clinically indicated



## **Therapy Activity**

The referrals that have met the requirements of the minimum data set, otherwise known as the accepted referrals, will be triaged weekly by relevant members of the team. If the patient is suitable for therapy, they will be offered a single, multi or inter-disciplinary appointment.

Once placed on the waiting list, patients will be contacted by the administration staff.

When fully staffed, the average waiting time is two months. The waiting list is managed according to a variety of criteria;

- Chronological order
- Interdisciplinary requirement of the patient
- Significant clinical need.
- Other such as place available in a group

Appointment times are scheduled with individual therapists and agreed with the person and their family/carer. All appointments are logged onto PAS.

Each person's programme of therapy will differ in length. The duration of the programme will be decided upon and agreed during the assessment phase and reviewed throughout the course of therapy treatment.

Persons may need to see one or more therapists during a single day and this will be facilitated through scheduling and interdisciplinary working.

Persons attending Outpatient Therapy are also seen for routine medical review, however, should an urgent issue arise during treatment then a special medical review with the Consultant in Rehabilitation Medicine will be arranged.

### **Discharge Criteria for BI Outpatient Therapy Programme**

To be discharged from the BI/OP at the NRH, one or more of the following must be true:

1. The patient has met their agreed goal or received the maximum benefit from the therapy programme
2. The patient experiences major intervening surgical and medical problems that prevents them from participating in their therapy program
4. The patient's ongoing rehabilitation needs can best be met in an alternative environment or service
5. The patient is no longer willing or able to be an active participant in the outpatient programme
6. The patient is non-compliant with outpatient programme services or wishes to self discharge.
7. The patient misses their therapy appointments and falls within the **DNA policy** by:
  - Missing 2 consecutive therapy appointments without notification
  - Missing a total of 3 appointments with notification



## **HOME AND COMMUNITY BASED AND VOCATIONAL SERVICES**

### **(BI/HCB; BI/V)**

The Next Stage Rehabilitative Training Programme (Next Stage) at the National Rehabilitation Hospital (NRH) provides specialised, interdisciplinary, coordinated and individualised outcomes focused rehabilitation for people with acquired brain injury (ABI).

Next Stage is a national rehabilitative training service provider accepting referrals of people with an acquired brain injury (ABI) living throughout Ireland. The Next Stage Programme is designed to assist people with an acquired brain injury (ABI) to maximise their functional abilities and achieve their individual desired training goals. Goals may be greater levels of independence and community reintegration; and/or increased personal, life, social, behavioural and practical. The Next Stage Programme also assists persons who have specific goals of returning to work and education by assessing their needs and abilities, improving necessary skills, offering work/educational sampling and then help them make informed choices regarding future training, educational or vocational options. The Next Stage Programme also helps link persons to appropriate health, employment or community services to facilitate and implement these goals.

#### **Main Aims of the Next Stage Programme**

- To improve functional abilities and develop personal, life, social, practical, and work related skills
- Increase levels of independence & community re-integration
- Provide individualised and effective training
- Provide a safe and graded learning environment
- Retrain previous skills and to learn new skills
- Provide a work like structure to the daily routine
- Provide educational support and computer training
- Liaison and referral with various support organisations
- Assist individuals in making informed choices regarding future training, educational and /or vocational options

The Next Stage Programme, in conjunction with the persons served and their families/carers, provides individualised, goal-directed rehabilitative training designed to lessen the impact of impairment and to assist people with ABI to achieve their desired levels of functional independence, social participation and

community reintegration. While trainees will have a common disability, the effects of brain injury are diverse. Therefore, the training programme is designed to meet individual needs and goals in a client centred format by providing a high-quality and individualised training programme. The necessary qualifying factor for entry is that applicants show insight, ability to identify training goals, potential and motivation to move on to their own Next Stage.

The services of the Next Stage programme are provided by an interdisciplinary team through a case-coordinated approach that also addresses:

- Ongoing access to information, referral and transition to services available within the NRH Brain Injury Continuum of care.
- Support for information sharing, movement and access with other external brain injury community resources and stakeholders.
- Provision of education and support to persons served and their families/support systems and the community.
- Facilitation of opportunity for interaction for people with ABI within the NRH Brain Injury Continuum of care

This comprehensive interdisciplinary system of continuum of care ensures that all individuals can receive the most appropriate programme of care based on their injury and their individual rehabilitation needs. Treatment can begin anywhere in this continuum, and persons served can progress through this continuum and to other appropriate community and follow-up services.

### **Rehabilitation Setting**

The Next Stage programme is able to facilitate up to 18 full time equivalent trainees. The unit has a training resource room, computer room, conference room, kitchen, manager's office, counselling room, individual treatment room and a general office.

As Next Stage is a national programme, those living outside commutable distance may avail of accommodation in Corofin Millennium Lodge.

The Corofin Millennium Lodge is an 11-bedded residential facility located in the Rehabilitative Training Unit. It has twin, single, carer and high dependency room and can offer accommodation to all levels of ability (PA required for trainees who require assistance with their activities of daily living). It also has common and quiet areas. All areas including bathrooms and lifts cater for trainees in wheelchairs or with mobility difficulties. The lodge is open Sunday evening to Friday morning.

For trainees who reside in the lodge there is a €15/night fee. This fee may be reimbursed from either the HSE or Department of Social and Family Affairs depending on eligibility requirements.

### **Programme Duration and Hours**

Trainees attend up to five days/week (~30 hour week)

Hours: 9.30 am to 5.00 pm; Monday to Thursday

9.30 am to 1.00 pm; Fridays

Closed Saturday; Corofin Lodge opens Sunday evenings (6.00 pm)

The average programme duration is 8.6 months. However, this duration can vary to meet the individual needs and goals of the trainees. Some trainees may not need to avail of all the modules in the programme, or some might require extra training to meet their particular needs and goals. Some trainees will attend on a part-time or graduated basis due to the constraints of their disability or to accommodate relevant work or other training needs.

### **Admission Criteria:**

To be admitted into the Next Stage programme at the NRH, the individual must:

1. Have one of the following:
  - a. Acquired brain injury (ABI) is an inclusive category that embraces acute (rapid onset) brain injury of any cause, including:
    - i. trauma – due to head injury or post-surgical damage
    - ii. vascular accident (stroke or subarachnoid haemorrhage)
    - iii. cerebral anoxia
    - iv. other toxic or metabolic insult (e.g. hypoglycaemia)
    - v. Infection (e.g. meningitis, encephalitis) or other inflammation (e.g. vasculitis).
  - b. Have medical, cognitive, physical, communicative and/or behavioural needs related to the neurological injury or disease process.
2. Be aged 18 to 64 years at time of admission.
3. Have the potential, and level of insight, to develop greater functional independence and to actively participate in group training.
4. Be able to arrange own transportation to/from the RTU
5. Be independent in their personal activities of daily living.
6. Be able to co-operate and work with the facilitator's and other trainee's.

Admission to the Next Stage programme is based on the outcome of the initial interview and the meeting of the programme's admission criteria. The timing of admission to the programme is approximately 9 months from receipt of referral, but may be influenced by delays in discharge and limited availability of lodge accommodation.

### **Exclusion Criteria:**

Persons with ABI are excluded from the Next Stage programme where other needs (e.g. medical/psychiatric/behavioural/drug and substance misuse), predominate over the potential to benefit from specialised rehabilitation training and the cognitive, physical and psycho-social needs of the patient. In these cases recommendations may be made to the referring agent regarding other more appropriate services. Additionally, if the person is not independent in their self-care and medication management, they are required to have appropriate supports e.g. a PA or Carer.

### **Discharge Criteria:**

To be discharged from the Next Stage programme at the NRH, one or more of the following must be true:

1. The person has achieved their identified training goals and is deemed to have received maximum benefit from the rehabilitative training programme.
2. The person has improved to the projected functional level that will allow discharge to another specified environment or service.
3. The person experiences major intervening surgical, medical and/or psychological problems that precludes further benefit from a continuing the training programme.
4. The person's ongoing rehabilitation needs can best be met in an alternative environment or service. Relevant services have been contacted and informed and the details provided to the person.

The person is no longer willing to be an active participant in the inpatient programme.  
(The Next Stage programme is strictly voluntary and person's can request to discontinue their programme at any stage)

The person is in breach of or non-compliant with programme services and policies.

### **The Services Provided For Trainees:**

Following appropriate referral to the RTU, the person will receive an initial assessment to identify their unique medical, physical, cognitive, communicative, psychological, social, behavioural, vocational, educational, cultural, family, spiritual and leisure needs. This is also an opportunity for persons referred to receive information about the RTU including characteristics of clients served, types of services offered, outcomes, and any other information. Following this assessment and if the person meets the RTU admission criteria, they may be offered admission to the programme.

Following admission the Trainee embarks on an induction period. During the induction period, a caseworker will be assigned to the client that will liaise with the client/family and also establish goals and outcomes with the client. After this induction period, the interdisciplinary team members, in collaboration with the client and their family/support network, will develop a comprehensive individual training plan that addresses the identified goals of the patient and their family/support network. Clients and their family/support network are offered appropriate information and opportunity for feedback at every stage of the rehabilitation process, and are actively involved in decisions regarding their training programme. Clients and their family/support network are also offered education on ABI and strategies to aid their rehabilitation.

### **Types of services offered by the Next Stage programme to meet identified needs could include:**

- Brain Injury Awareness & Management
- Education and Project support
- Information Technology
- Life Skills Management
- Personal and Social Development
- Vocational assessment, planning and exploration
- Discharge Planning

Furthermore, if additional services are required and not available on-site, the Next Stage programme can facilitate referral to certain ancillary services.

### **Examples of these ancillary services that the Next Stage programme can refer to include:**

- Advanced assistive technology assessment
- Physiotherapy Services (incl. Hydrotherapy)

- Medical assessment and management
- Speech & Language Therapy
- Medical speciality consulting including Psychiatry, Neuro-ophthalmology, Neuro-psychiatry.
- Occupational Therapy
- Substance abuse counselling

People with ABI in the RTU frequently have complex disabilities and needs which require specialist intervention by professionals with knowledge and experience in the management of brain injury. This is taken into consideration when an individual case worker is being assigned to each trainee. The composition of the NRH/RTU interdisciplinary team for each person served is determined by the assessment of the person's individual medical and rehabilitation needs. These team members could include:

- Counselling psychologist
- Education support facilitator
- Occupational therapist
- Rehabilitation medicine specialist
- Training facilitator
- Training manager

### **The Services provided For the Families, Carers and support systems of Person Served:**

Families and carers are partners in the rehabilitation process and are encouraged to participate in all phases of the programme. Information, counselling, emotional and psychological support can reduce the emotional sequelae experienced by the family/carer. This support may help them to adapt and come to terms with life changes, and so result in better long-term outcomes for both the patient and the family. Rehabilitation is a continuous and life long process. The carrying over of new skills gained in treatment into daily activities and into discharge environments is critical to the success of any rehabilitation programme.

Many services are available within the Next Stage programme to meet the needs of the patient's family/carers including:

- Education/training about management of ABI related issues (e.g. Family Conferences, printed resource material, informal instruction and practical skills training in preparation for discharge).

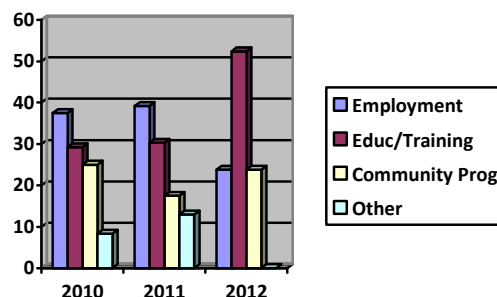
- Psychological support services
- Peer support through interaction with other families and various community support groups (e.g. Brí, ABII and Headway Ireland).
- Information about community support, Trainee progress within the service, advocacy, accommodation and assistive technology resources.
- Yearly organised Family ‘Information Days’
- Trial of supported living on site in our short stay independent living facility
- Each trainee is assigned their own case worker at time of induction. Case worker is the primary point of contact for family/carers and will attend medical reviews with the family and facilitate family meetings with RTU team and/or community service providers.

### **Discharge Outcomes and Environments**

The Next Stage programme aims to discharge all trainees after they have achieved their rehabilitation training goals and received maximum benefit from the programme. The Next Stage programme strives at all times to discharge patients to their most appropriate and desired discharge environment, taking into consideration the patient’s and families wishes, their clinical and functional status, legal restrictions and availability of community and home supports. The trainee’s are encouraged to avail of any further support services that we identify for them in their locality e.g. VEC services, FAS, NLN etc.

Acceptable outcomes for our Next Stage Programme could include further training, education, employment, community programmes, health gain and/or social gain.

The RTU has continued over the years to secure excellent outcomes for the trainees of the programme.



Outcomes for RTU trainees are also measured using the Mayo Portland Adaptability Inventory; where gains are measured in terms of ability, adjustment and participation.



## APPENDICES

### Appendix 1: Outpatient OT Scope of Service

#### OUTPATIENT OCCUPATIONAL THERAPY SCOPE OF SERVICE

The Occupational Therapy Team provide an outpatient service to patients under the care of medical consultants at the National Rehabilitation Hospital.

The aim of this outpatient service is to provide specialist assessment and intervention to enable individual patients to maximise their occupational performance, despite the limitations imposed by neurological impairment secondary to a brain injury or spinal injury. The service also supports the families/significant others of patients, through interventions of an educational and/or advisory nature.

#### **Staffing**

The outpatient service is staffed by 1 WTE Senior Occupational Therapist. This position is currently shared by two members of staff each working in a 0.5 WTE capacity.

#### **Format of Service Delivery**

Occupational Therapy provision to the outpatient service is provided in three formats:

- 1) Attendance at Multi-disciplinary Clinics in an advisory/consultative capacity.
- 2) Single discipline assessment and intervention (i.e. therapy sessions provided by an Occupational Therapists for a single patients and/or group of patients)
- 3) Inter-disciplinary assessment and intervention (i.e.. therapy sessions provided by an Occupational Therapist together with a colleague from another discipline, usually a Speech and Language Therapist and/or a Physiotherapist). Inter-disciplinary therapy sessions are conducted when therapists are working on shared therapy goals with an individual patient/s.

#### **Multi-disciplinary Clinics**

Occupational Therapists attend the following outpatient multi-disciplinary clinics:

- Dr. Carroll's Clinic (Brain Injury) 2<sup>nd</sup> Monday each month



- Dr. McElligott's Clinic (Spasticity Management) - 3<sup>rd</sup> Monday each month
- Dr. Delargy's Clinic (Brain injury)- 4<sup>th</sup> Monday each month
- Dr. Smiths weekly spinal clinic - Wednesdays

In the clinic setting Occupational Therapists provide specialist advice and information on:

- The assessment and management of occupational performance components affected by neurological impairment e.g. physical, sensory, cognitive, perceptual, intra-personal and interpersonal abilities.
- Occupational participation - performance of daily occupations including self-care, domestic tasks, leisure pursuits and work.
- Specific interventions available through the Occupational Therapy Service e.g. patient and family educational interventions, cognitive rehabilitation, splinting, return to driving assessment, vocational assessment, etc....
- -services available from other providers.

The Occupational Therapist will also contribute to multi-disciplinary decision making. Decisions made at clinic may relate to:

- the patients appropriateness/potential to benefit from an inpatient admission at the NRH
- the patients suitability/appropriateness to attend outpatient services at the NRH
- the patients need for referral to other services

### **Referral Process/Pathway for Outpatient Occupational Therapy**

(Single and Multi-disciplinary)

Patients must be under the care of a Medical Consultant at the National Rehabilitation Hospital to access this service.

Patients remain under the care of the NRH referring consultant for the duration of their therapy programme at the NRH. Medical follow up review is available for these patients if requested by the therapy team. It is acknowledged that therapy is offered in the team framework and support service are available to support this structure and process.

Referrals are only accepted from staff of the NRH. This includes:

- Medical Consultants and/or a member of the medical team
- Inpatient therapist
- Outpatient therapists

All referrals must be in written format clearly stating the referrer's goals for Outpatient Occupational Therapy intervention.

### **Management of Referrals**

On receipt of referral, a paper based screening is conducted based on the referral information received, before the patient is wait-listed for services. This process ensures that patients meet the admission criteria for the outpatient occupational therapy service (see below).

If a patient does not meet the criteria for admission to the service, the referrer will be advised in writing with clear reasoning for the decision.

If a patient meets the criteria for admission to the service, they are placed on the waiting list.

The waiting list is managed in chronological order however, if an interdisciplinary team assessment is indicated, the individual will be seen when team members are collectively free to see the patient.

Note: Interdisciplinary team assessments are indicated when a patient presents with multiple needs which cannot be address appropriately or effectively through a uni-disciplinary assessment

### **Admission Criteria**

Patients must meet the following criteria to avail of Outpatient Occupational Therapy:

- Be aged 18 years or older at the time of referral
- Have one of the following medical conditions:
  - a) Acquired Brain Injury (ABI). This is an inclusive category that embraces acute (rapid onset) brain injury of any cause.
  - b) Spinal Cord Injury
- Have a neurological impairment and/or limitation in occupational performance (i.e. self-care, domestic and community participation, vocational and leisure occupations) which is most appropriately addressed in an outpatient setting.

Note: The Occupational Therapy Team acknowledges the importance of the patient's environment (physical, social and cultural) as a contributory factor to effective occupational performance. For this reason, patients may be referred to community services when it is considered most appropriate for

the identified patient need to be addressed in their home or community environment (e.g. self-care training/practice, community skills training, provision of community equipment).

- Have the potential to benefit from specialised outpatient occupational therapy
- Have own transportation to/from the outpatient service

### **Exclusion Criteria**

Persons are not appropriate for the OPD OT service when:

- Other needs (e.g. medical/psychiatric/behavioural/drug and substance misuse) predominate over the potential to benefit from the service. In these cases, the referring agent will be notified in writing that the patient does not meet admission criteria for the service.
- Referrals are solely for driving assessment in isolation. Referrals of this nature should be direct to the National Driving Service of the Irish Wheelchair Association.
- Referrals are for occupational performance limitations which are best explored in the patient's own environment (e.g. ADL training, access issues, equipment issues) will be directed to our colleagues in the community OT service.

### **Patient Pathway through the Outpatient Occupational Therapy Service**

- Patients and/or their families, as appropriate, will be contacted by telephone to explain the role of Outpatient Occupational Therapy Service and arrange an appointment time.
- A written letter confirming appointment will be sent to the patient and copied to the referrer.
- An initial interview is completed at the first session. This may be uni-disciplinary or interdisciplinary in nature depending on the needs of the patients (as identified by the referrer, the patient him/herself and/or the patients family) The aim of the initial interviews is to identify/clarify the goals of intervention
- The patient will have a series of sessions, usually on a weekly basis for a period of 6 weeks.

This number of sessions may not be indicated for all patients, particularly if the goals of intervention are achieved in a shorter period.

Other patients may have outstanding achievable goals after 6 sessions and the Occupational Therapist may consider additional sessions where appropriate.

- When Outpatient Occupational Therapy Intervention is terminated, a discharge report will be generated for the referrer.

### **Outpatient Occupational Therapy Interventions**

- Assessment of occupational performance
- Goal setting
- Design and implementation of a goal focused outpatient rehabilitation programme
- Guidance and training for specific occupation performance deficits
- Physical rehabilitation including management of upper limb impairment
- Splinting
- Cognitive assessment and rehabilitation
- Driving assessment service
- Screening for vocational assessment services
- Specialist education for patients, families and carers.
- Referral and liaison with internal services at the NRH as appropriate (e.g. the Rehabilitation Training Unit, Vocational Assessment Occupational Therapist)
- Referral and Liaison with external agencies (including Headway, ABI Ireland, community OT and local ABI teams).

### **Equipment**

The Outpatient Occupational Therapy Service does not provide take home equipment for individual patients (e.g. equipment for rehabilitation at home and/or equipment for activities of daily living).

Where equipment needs are identified, it is the policy of the service to refer the patient to the Community Occupational Therapist in the area where they reside.

### **Attendance Policy**

If a patient cannot attend an appointment they are required to notify their therapist at least 24 hours before the appointment time. In this situation, the patient will be offered an alternative appointment.

Failure to notify the department will be regarded as a non attendance.

Two non attendances without notification will result in the patient being discharged from the service. The referrer and patient will be notified in writing should this occur.

### **Discharge Criteria:**

Patients will be discharged when:

1. Agreed goals as set on admission have been achieved and no other appropriate achievable goals are identified
2. The person's ongoing rehabilitation needs are best met in an alternative environment
3. On occasion, major intervening circumstances may deem it appropriate to cease intervention for example, the person experiences major intervening surgical, medical and/or psychological problems that precludes further benefit from the outpatient rehabilitation programme
4. The person is no longer willing to be an active participant in the outpatient programme.

### **Statistical Data**

Statistics are submitted on a monthly basis to the Occupational Therapy Manager using an excel template. The template is stored in the statistics file in the OT common folder.

## Appendix 2: Outpatient Clinical Psychology Scope of Service

### Clinical Psychology Out-patient Service National Rehabilitation Hospital

**Description:** The Out-patient Clinical Psychology Service at the NRH provides clinical consultation, assessment and therapy to the persons served at the NRH.

**Services provided by Clinical Psychology at OPD:** The clinical services provided by the Psychologists within the OPD include clinical assessments, psychotherapy and consultations including assessment of competency, capacity, cognitive functioning, personality, emotional status and behaviour. Interventions include a range of psychotherapies, psycho education, behaviour programmes, consultation and collaboration with other professionals, agencies, carers/families. These clinical duties can be delivered directly with the person served, family/carers, within dedicated clinical and therapeutic groups and or with other agencies and personnel as clinically determined. The OPD service also uses teleconferencing in order to facilitate efficient and effective delivery of services.

**Interdisciplinary Collaboration:** The Psychology OPD service endeavours to respond to the request and need of the person served ranging from single consultation to collaboration with the patient and the interdisciplinary outpatient team including the Rehabilitative Training Unit, Vocational Assessment, the School and the Neurobehaviour Clinic as well as external agencies for example, community based Brain Injury services, schools/colleges and employers.

The Neurobehaviour Clinic is a specialist clinic for adults with ABI who are experiencing significant personality and behaviour change as a result of the ABI. It serves both in-patient and out-patients, though predominantly the latter group. It is attended by one Consultant in Rehabilitation Medicine, one Neuropsychiatrist and one Clinical Neuropsychologist. This clinic (3 sessions per month) is served by the Clinical Neuropsychologist from the out-patient service.

**Programmes Included:** Person's served as part of the OPD service are predominantly from the Adult BIP and Paediatric Programmes.

Referrals from the Spinal and Polar programmes are accepted in special circumstances when it is considered by the Referrer and the relevant Psychologist to be clinically expedient and or appropriate for example, if the person served knows the Psychologist from their in-patient admission.

The number of such referrals from the Spinal Programme is approximately 8 per year and from the Polar Programme 6 per year.

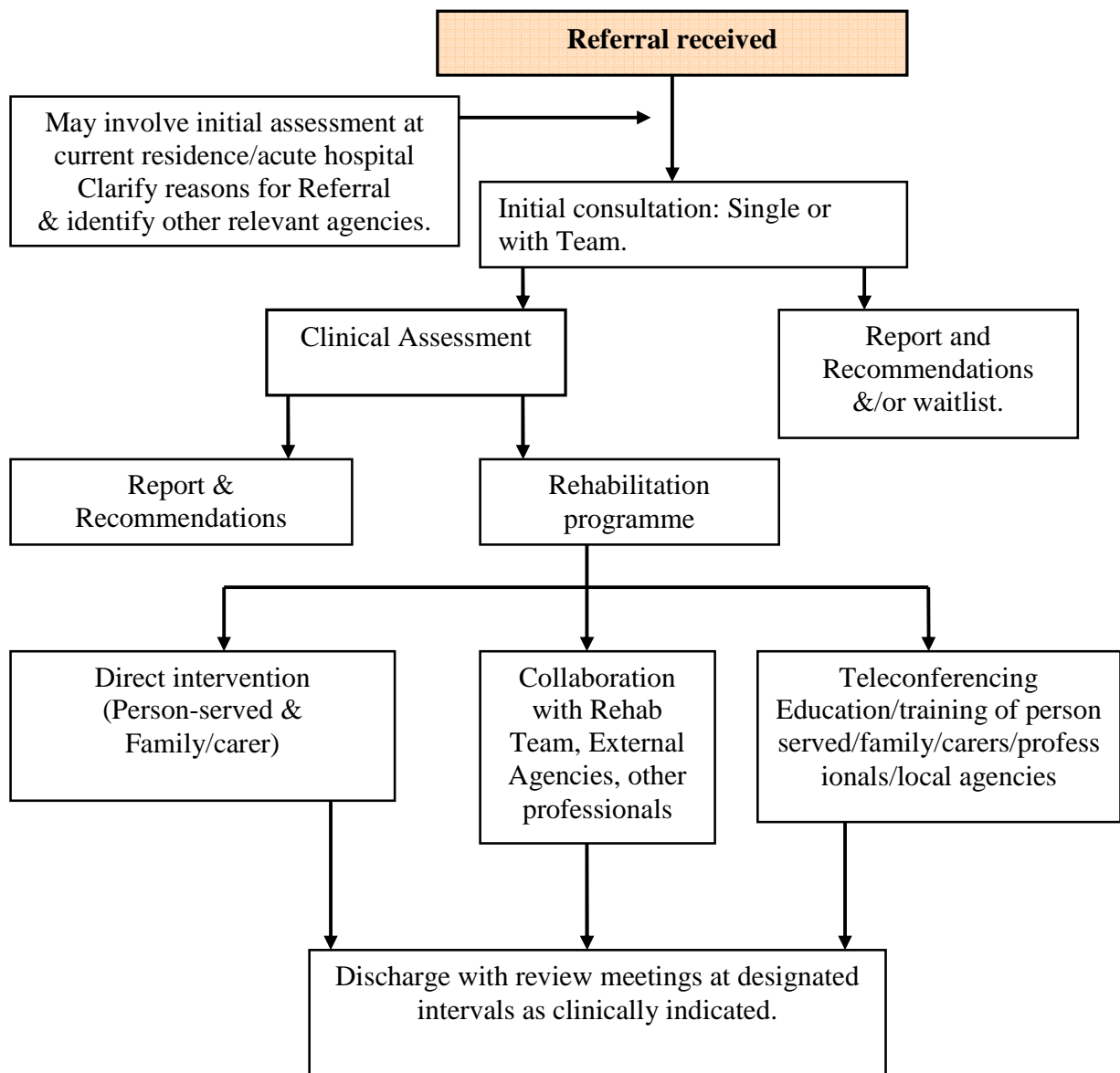
**Clinical allocation:** The whole-time equivalent personnel dedicated to OPD are equivalent to approximately 0.5 WTE/2.5 days per week. To date this allocation has been divided to 2 days for the Adult Out-patient Brain Injury programme and 0.5 day to the Paediatric Programme.

**Referral Process:** The OPD Psychology Service accepts the following referrals:

1. Person's served who are registered with the NRH and or are referred by the Consultants in Rehabilitation Medicine. These include ex-in-patients, current out-patients or prospective patients to NRH.
2. Persons served referred by the OPD Team, Paediatric team and school, Vocational assessment service and the RTU.
3. Referrals are accepted by letter, referral form, at the OPD Team meetings and by the Paediatric Team. Referrals may be discussed further with the referrer in order to clarify the referral and if appropriate, to suggest referral to other agencies/personnel.
4. A joint assessment with the OPD Team may be undertaken in order to undertake a preliminary assessment of the person served before offering further assessment or therapy.
5. Adult referrals are selected to see the Psychologist by date of referral and clinical priority as discussed with the referrer and or the OPD Team. Paediatric referrals are usually pre-planned with the Psychologist in collaboration with the Nurse Manager, Programme Manager and correspondence is co-ordinated by the Paediatric Programme secretary
6. It is planned that from November 2009, when a referral is made and accepted, a letter will be written to the patient, stating the reason for the referral by the referrer and the estimated time frame when the first appointment will be offered. This correspondence will be copied to the referrer.

The Referral Pathway and Clinical Course for persons served in Outpatients Psychology is illustrated below.





**Clinical Course:** Preliminary clinical interview and assessment is usually completed at the first session where the primary needs and goals are identified with the person served and the family/carers, as appropriate.

The frequency of sessions is determined by the clinical need of the person served based on the preliminary evaluation and this is reviewed following each session.

**Documentation:** After the preliminary assessment, the clinical opinion and recommendations are reported in the HCR or are documented by letter to the



referrer. Subsequent sessions are recorded in the HCR and when the episode of care has been completed a final report is written to the referrer or into the HCR.

**Admission Criteria:** Persons served who are referred to the Psychology OPD should have the following:

An acquired brain and or spinal injury and or limb loss and have cognitive, emotional and or behavioural needs related to this diagnosis.

Have the potential to benefit from psychological input.

Be willing to participate in the service as clinically indicated

**Exclusion Criteria:** Persons served who have the following will be excluded from the Psychology OPD:

Persons served who have a congenital diagnosis

Persons served whose primary diagnosis is psychiatric e.g. Conversion disorder, Borderline personality.

Where person served has access to a Clinical Psychologist within an agency they are currently attending e.g. CPI. This excludes referrals where specific psychological expertise is requested.

**Discharge Criteria:** Persons served will be discharged from OPD Psychology service in the following circumstances:

The person served has achieved his/her goals as agreed at preliminary assessment.

It emerges during the assessment and or intervention that the person's goals and needs can be better met with another agency or service.

If the person served is not able to participate in therapy due to unforeseen circumstances for example, decline in physical health and or unexpected stressful events.

The persons served capacity to continue to benefit and or achieve his/her goals has reached a plateau.

The person served is no longer willing to be an active participant in the programme.

**Non Attendance:** If the person served cannot attend the session offered and has notified the Out-patient administrators or the Psychologist, they are offered another session. If the patient fails to attend that session, they are offered another time and asked to confirm that they will attend. If the person served fails to attend the second appointment, the patient and the referrer will be informed that they have been discharged from the service.

**Statistics:** Statistics regarding OPD attendance, type of activity (assessment, therapy, consult) and diagnostic category of patient are gathered each month.

## **Appendix 3: Outpatient SLT Scope of Service**

### **Speech & Language Therapy Out Patient Department Scope of Practice**

#### **Our Goal**

To empower the person, caregiver and family with education so they can achieve independence in their communication skills with or without support. We are committed to enhancing communication and we aim to enable people to communicate to the best of their ability and promote recovery of communication to maximise quality of life

#### **Programme description**

The SLT OPD Rehabilitation Programme is an individualised, coordinated outcome focused programme that optimises the activities and participation of the persons served and their families. The SLT OPD is part of an Interdisciplinary Outpatient programme which focuses on meeting the needs of persons served through a coordinated service approach.

#### **Range of services provided by SLT OPD**

SLT provides provision to the OPD service in three formats

1. Individual Single discipline Therapy sessions
2. Multi-disciplinary Team Assessment Clinics (see below)
3. Interdisciplinary assessments and interventions, either for assessment or for joint sessions with a colleague from OT
4. Group therapy sessions for clients and family members

#### **Multi Disciplinary Team Assessment Clinics**

These are clinics that are led by the Consultant where the SLT meets with family and patients and acts in an advisory capacity and contributes to the multi-disciplinary decision making. Outcomes from these clinics include:

- Suitability for an out patient treatment programme
- Suitability for benefit from inpatient services, using a priority needs analysis (see enclosed form)
- Referral to local community services
- Liaison with community services and outside agencies, e.g. ABI Ireland
- Advice to families
- Advice to referring agents

### **Clinics served**

- Dr Carroll brain injury clinic 2<sup>nd</sup> Monday of the month
- Dr Delargy brain injury clinic 4<sup>th</sup> and 5<sup>th</sup> Monday of each month
- One hour Dr Delargy review clinic Thursday morning

### **Therapy Pathway**

Clients accessing SLT services at the NRH must be under the care of a National Rehabilitation Hospital Medical consultant, and have a MRN Number. Patients must remain under the care of the NRH consultant for the duration of their therapy programme at the NRH. Medical follow up review should be available for these patients if requested by a member of the therapy team.

Referrals will be accepted from:

- Inpatients transferring to outpatients via the inpatient therapist
- Other OPD therapists
- From consultant led multi-disciplinary clinics at the NRH
- Directly from NRH consultants (6 consultants)
- From NRH consultants attending other hospital services
- From the RTU at NRH.
- From Community/hospital based SLT via the consultant

### **Referral Process for SLT Therapy**

- Only written referrals can be accepted i.e. completed referral form or a referral letter.
- The clients name is logged onto the waiting list once the referral is received. Some preliminary work is done prior to a therapy appointment to indicate the type of SLT intervention that may be required. Patients are managed from the waiting list chronologically. However if an interdisciplinary team assessment is indicated the client will be seen when team members are available to see the client.
- If a patient is assessed and will require other disciplines as part of their SLT Rehabilitation goals their programme, in collaboration with the client, may be held until an interdisciplinary programme may be offered
- Patients are contacted by telephone and/or letter to arrange an appointment time.
- A written letter confirming appointment is sent to the patient and copied to the referring person
- An initial interview is completed at the first session. The aim of this is to identify goals for the intervention process.

- Patient will have a series of sessions which will include a review of their goals.
- The frequency of sessions depends on the needs of the individual but will rarely exceed 2/3 in a week.
- A discharge report will be generated for the referrer.

### **Admission criteria**

To be admitted into SLT OPD, the individual must:

1. Have one of the following:
  - a. Acquired brain injury (ABI) is an inclusive category that embraces acute (rapid onset) brain injury of any cause, including:
    - i. trauma – due to head injury or post-surgical damage
    - ii. vascular accident (stroke or subarachnoid haemorrhage)
    - iii. cerebral anoxia
    - iv. other toxic or metabolic insult (e.g. hypoglycaemia)
    - v. Infection (e.g. meningitis, encephalitis) or other inflammation (e.g. vasculitis).
  - b. Have medical, cognitive, physical, communicative and/or behavioural needs related to the neurological injury or disease process.
2. Adult 18 and above at time of admission.
3. Have identified medical, cognitive, physical, communication and/or behavioural needs, which cannot be met in an inpatient, community or home rehabilitation setting.
4. Have the potential to benefit from specialised outpatient rehabilitation
5. Be willing to actively participate in setting rehabilitation goals
6. Be able to be left unattended before and after sessions or have a relative in attendance.
7. Be medically, physically and mentally stable in order to regularly attend and participate in therapies
8. Be independently mobile or have someone to assist them
9. Be able to secure reliable transportation to and from outpatients appointments
10. Willingness to accept recommendations of the interdisciplinary team concerning medical, psychiatric and other conditions that interfere with ability to progress toward goal

### **Exclusion Criteria**

- Clients whose primary needs are dysphagic or who are not under the management of a dysphagic clinician
- Clients who have a longstanding or a progressive illness.

- Persons are not appropriate for the OPD SLT service where other needs (e.g. medical/psychiatric/behavioural/drug and substance misuse), predominate over the potential to benefit from the service. In these cases, the referring agent will be made aware we cannot meet the patient's needs.

### **Scope of Clinical Practice**

Service will provide assessment and intervention to address specific language, speech and cognitive communicative goals

- In depth language, speech and cognitive-communicative skills assessment.
- A plan is agreed with the patient following assessment indicating what the treatment programme will entail. This may be written for the patient for their records. During the treatment period goals are reviewed and revised where indicated.
- Home programmes to supplement weekly attendances
- Education and advice to family members is an integral part of OPD SLT service
- Joint working and sessions with other members of the multi disciplinary team
- Referral and liaison with other external agencies (including Headway, ABI Ireland, Local SLT services V.S.S.)
- COPA (Community Outing Performance Appraisal)
- Group sessions
  - Meet & Teach for patients with OT colleague
  - Meet & Teach for Families with OT colleague
  - Living with Aphasia for people with aphasia
  - SPPARC for family members of people with aphasia

Frequency of sessions will be determined on an individual case basis.

Some patients from outside the Dublin region may be seen for more intensive assessment/therapy periods over a 2 week period.

Some clients are seen for a block of treatment and then put on review for a further input at a later date.

### **Non Attendance**

If a patient cannot attend for their appointment and notify the department then they will be offered a further appointment. Failure to notify the department will be regarded as a non attendance. Two non attendances in a six week period without

explanation and the patient will be discharged from the service and the referrer will be notified in writing

**Discharge Criteria:**

To be discharged from outpatient SLT, one or more of the following must be true:

1. The person has achieved agreed goals for the period of intervention
2. The patient has improved to the projected functional level that will allow discharge
3. The person's ongoing rehabilitation needs can best be met in an alternative environment
4. On occasion, major intervening circumstances may deem it appropriate to defer intervention - The person experiences major intervening surgical, medical and/or psychological problems that precludes further benefit from a continuing outpatient rehabilitation programme
5. The progress has reached a plateau
6. The person is no longer willing to be an active participant in the outpatient programme.
7. The person is non-compliant with programme services.

**Statistics**

Statistics are submitted on a monthly basis using an excel template, to the SLT Manager.

**Communications within the OPD Service**

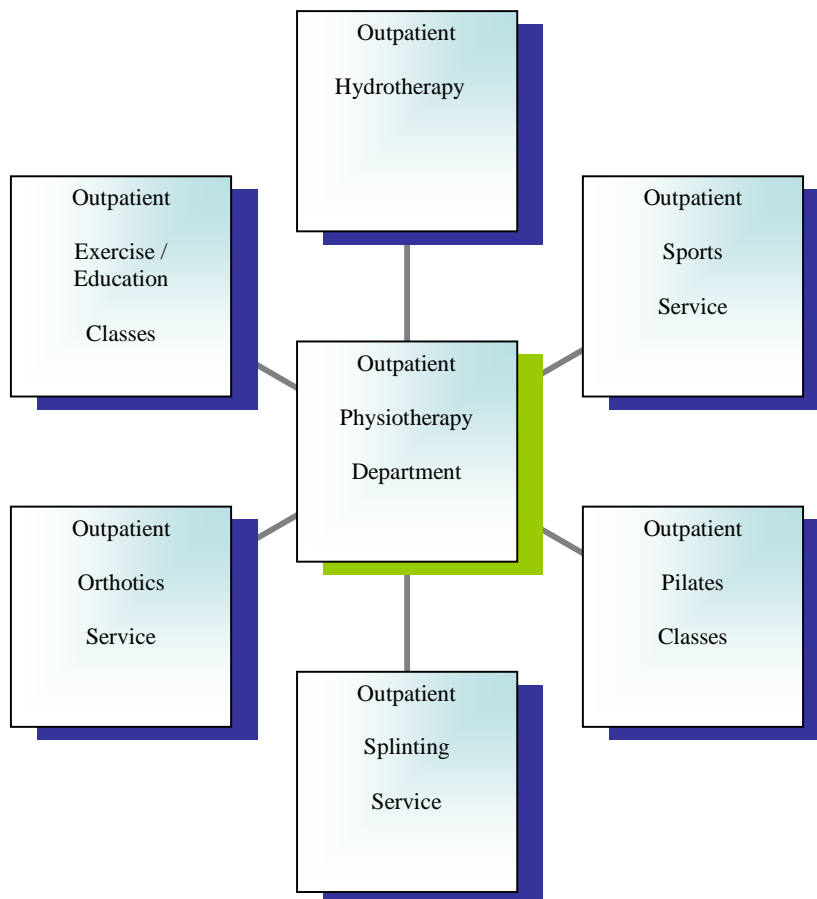
The waiting list is held in the OPD Common folder.  
Service development meetings are held twice monthly

## Appendix 4: Outpatient PT Scope of Service

### Physiotherapy Outpatient Therapy Services in the National Rehabilitation Hospital

#### Physiotherapy Outpatient Department:

It is the policy of the Outpatient Physiotherapy Department to accept patient referrals from NRH consultants only. Referrals to all services affiliated to the Outpatient Physiotherapy Department must be referred to the main outpatient physiotherapy department for processing in order to access other services.





## **Access to Outpatient Physiotherapy Services at the National Rehabilitation Hospital (NRH)**

Patients accessing Outpatient Physiotherapy services at the NRH must be under the care of an NRH consultant.

Referrals will be accepted (once agreed with treating NRH Consultant);

- For inpatients transferring to outpatients
- From therapy services within the NRH
- From support services within the NRH via the patient's consultant at the NRH
- From consultant led clinics at the NRH
- From NRH consultants operating out of their other clinics
- From Occupational Health referring staff members injured at work

Referrals should be made on the official referral form for services within the NRH. This must be accompanied by a full report or discharge summary. This is particularly important if the patient is to receive an appointment in a timely fashion.

Referral forms are available on the NRH common folder and can be sent by e-mail to OPD Physio on outlook express. The referral must be accompanied or followed up with the report documents in order to activate the referral proper.

### **Referral management:**

A waiting list applies to all patients referred to outpatient physiotherapy services. Patients are seen in chronological order from receipt of referral, unless they require team involvement in which case they are appointed as soon as the team members are collectively free to see that patient.

Patients are initially contacted by telephone to check on their status and current needs. This screening may identify that there is no need for outpatient Physiotherapy and a report to that effect is generated for the patient's health care records.

If treatment is indicated patients are offered an initial appointment for an assessment and objective measures are recorded at that time. If the patient is for another outpatient service they are then referred on to that service following base line assessments. At the end of the period of treatment intervention in those services the patient's therapy notes may be returned to the OPD Physiotherapy service for future reference. At this point if a review is undertaken a report is generated for the referrer and a copy is sent to the patient's health care record.

### **Scope of clinical practice:**

Patients who are treated in the OPD Physiotherapy service are assessed, problems are identified and goals are agreed with the patient. Problem/goal orientated therapy records are generated at this initial assessment.

A plan is outlined to the patient indicating what actions will be taken during the treatment period. During the treatment period goals are reviewed with the patient at intervals and revised if appropriate.

Following treatment in OPD Physiotherapy service the patient's objective measures are repeated and the goals are reviewed prior to their discharge. Education is a key component of the therapy process and permeates all treatment sessions.

It may be appropriate to arrange one or more of the following for the patient

- A home exercise programme (a)
- An appointment to return for follow up review (b)
- An appointment to attend an exercise class at the NRH (c)
- A referral to community services (d)

A discharge report is then generated for the referrers' records and a copy is sent to the patient's health care records.

- a. Home exercise programmes are usually generated with 'Physio Tools' which is a computer programme. The exercises are designed to enable the patient to continue to benefit from exercise following discharge from the hospital.
- b. Review appointments are used to monitor the patient in terms of coping with their home programme, checking for further physical progress or recalling them for orthotics or necessary equipment.
- c. Exercise classes run in blocks of six week periods. It is not always possible to facilitate the patient in these classes during their time attending for outpatient physiotherapy although every effort is made to do just that. In the event that it is not possible they are put on a waiting list and called back for the next available class.
- d. The outpatient physiotherapy service maintains close contact with community services in the management of our patients overall needs and requirements via mail, telephone and e-mail.

### **Equipment policy:**

The outpatient physiotherapy department has no budget for the purchase of equipment for individual patients. It is the policy of the department to recommend equipment for patients directly to the appropriate community health care team if the patient has a medical card. Otherwise the patient is advised directly and confirmation notes are supplied for their insurance provider.

All recommendations for equipment will be made in the standard requisition book and are usually accompanied by a quote from the supplying company before being submitted through the Occupational therapy Department to the community services.

A record of the recommendation is kept in the patient's therapy notes.

### **Admission Criteria:**

Patients attending the OPD Physiotherapy service will be individuals whose diagnosis falls into one of the following categories, TBI, BI, CVA, SCI, other neurological conditions and whose needs can be met by the service at the time of referral. They are

- Adults aged 18 or over
- Have the potential to benefit from specialised outpatient rehabilitation
- Are medically and mentally stable
- Are willing to participate in the goal setting that is an essential component of the outpatient rehabilitation programme
- Are willing to engage in the rehabilitation process and accept therapy recommendations
- Have transport arrangements in place to get to and from appointments

In addition the OPD Physiotherapy service is available to staff referred through the Occupational Health Department who have sustained an injury through work related activities. This service is only available when staffing levels permit.

### **Exclusion criteria:**

- Paediatric patients
- Limb absence patients
- Violent /abusive patients
- Patients whose needs can not be met by the service
- Patients whose other needs (e.g. medical/psychiatric/behaviour/drug and substance misuse)predominate over the potential to benefit from the service

### **Non Attendance**

If a patient cannot attend for their appointment and notify the department as soon as is possible then they will be offered a further appointment. Failure to notify the department will be regarded as a non attendance. Two non attendances without explanation and the patient will be discharged from the service and the referrer will be notified in writing.

Persistent cancellation of appointments would be discussed with the patient and may result in the patient being discharged or placed back on the waiting list until such time as they can commit to the outpatient programme.

### **Discharge Criteria:**

- Goals are met
- Needs of the patient are best met in another setting
- Patients condition has altered and they are no longer suitable for the service
- Patient has maximised their potential
- Patient no longer wishes to attend or is non compliant
- Persistent non attendance

### **Records:**

Statistical records are recorded monthly and submitted as part of the main Physiotherapy Departments statistics to the Health service Executive.

Waiting lists for individual therapy services and a joint waiting list are recorded on excel spread sheets and held on NRH common in the OPD folder.

Individual therapy records are kept in the OPD Physiotherapy gym.

Documentation pertaining to the patient is copied to that patient's health care record.

## **Appendix 5: Outpatient MSW Scope of Service**

### **THE SOCIAL WORK DEPARTMENT SCOPE OF SERVICE FOR OPD**

#### **The Social Work Service in OPD is offered to:**

- Multidisciplinary out-patient clinics and to general out-patient clinics
- To patients attending for treatment programmes such as ABI out-patient treatment
- To trainees attending the RTU
- To ex-patients of the Hospital who make contact with the Social Work Department directly
- To patients needing pre-admission intervention where appropriate e.g. support and advice to parents planning to stay at the NRH with their children

#### **Services Offered:**

- Psychosocial assessment of the patient and family's current situation
- Counselling – Patients and/or families  
Counselling is offered to Patients/Families in order to assist with managing the crisis /trauma, relationship issues, enhancing coping skills, grief and adjustment, work on solutions regarding preferred future options and to assist with other issues which present e.g. previous life experiences are often brought to the fore following a trauma such as SCI or ABI
- Information and Advice – entitlements, housing, addiction services etc.
- Liaison with a wide range of community services and organisations, voluntary agencies, schools by telephone, community conferences and/or teleconferencing
- Carer Training – SAC Programme is available to OPD families
- Child and Adult Protection intervention /consultation to other members of the team

**Programmes Served:** Person's served as part of the OPD service are from all four programmes. The Paediatric programme involves a considerable amount of OPD and outreach work since these children rotate in and out of the in-patient service and remain in contact with the Paediatric team on an ongoing basis.

**Staffing Allocation:** The whole-time equivalent staff allocation for OPD is approximately 0.75 WTE or 3.5 days per week.

Currently there is 0.5 days per week for the Paediatric Programme, 1 day per week for the SCI Programme (including the Vocational Programme), 1.5 days for the Adult Out-patient Brain Injury programme and 0.5 for the polar programme

It is not possible to meet the demands within this allocation and there is a waiting list system for adult ABI clients

**Referral Process:** The OPD service accepts referrals via:

1. Referrals by the Consultants in Rehabilitation Medicine or other members of the IDT teams. These include ex-in-patients, current out-patients or prospective patients to NRH.
2. Patients referred by the OPD Team
3. The Paediatric team/NRH school
4. Patients referred by services such as the RTU and the Vocational Assessment service

Referrals are sent via letter or the SW referral form.

Referrals may be discussed further with the referrer in order to clarify the reason this was requested and if appropriate, to suggest referral to other agencies/personnel.

A joint assessment with members of the OPD Team may be undertaken in order to undertake a preliminary assessment before offering further assessment or intervention.

Adult ABI referrals are put onto a waiting list on OPD common. An update of when the case is opened and what is being offered is also entered onto this folder. Referrals are prioritised by date of referral and clinical priority as discussed with the referrer and or the OPD Team.

Paediatric referrals are usually pre-planned by the Paediatric Team and correspondence is co-ordinated by the Paediatric Programme secretary

**Interventions:** An initial psychosocial assessment is usually completed at the first session where the primary needs and goals are identified with the person served and the family/carers, as appropriate.

The frequency of sessions is determined by the clinical need of the person served based on the preliminary evaluation and this is reviewed following each session.

Where appropriate, clients are referred to outside agencies such as HSE disability services, Headway, Citizen's Information Service etc

**Documentation:** The Social Worker records notes in the Social Work file and /or the HCR.

**Admission Criteria:** Persons served who are referred to the Social Work OPD service should

Within the NRH scope of service

Be willing to participate in the service

Have the potential to benefit from SW intervention

**Exclusion Criteria:** Persons served who have the following will be excluded from the SW OPD service

Persons served whose primary diagnosis is psychiatric e.g. Conversion disorder, Borderline personality although the family may be seen for advice/onward referral Where person served has access to a Social Worker within an agency they are currently attending e.g. CRC. This excludes referrals where specific NRH expertise is requested.

**Discharge Criteria:** Persons served (including the family/carers) will be discharged from OPD Social Work service in the following circumstances:

The person served has achieved his/her goals as agreed at preliminary assessment. It emerges during the assessment and or intervention that the person's goals and needs can be better met with another agency or service.

If the person served is not able to participate in therapy due to unforeseen circumstances for example, decline in physical health and or unexpected stressful events.

The persons served capacity to continue to benefit and or achieve his/her goals has reached a plateau.

The person served is no longer willing to be an active participant in the programme.

**Non Attendance:** If the person served cannot attend the session offered and has notified the Department Secretary or the Social Worker, they are offered another session. If the patient fails to attend that session, they are offered another time and asked to confirm that they will attend. If the person served fails to attend the second appointment, the patient and the referrer will be informed that they have been discharged from the service.

**Statistics:** Statistics regarding OPD attendance, type of activity (assessment, therapy, consult) and diagnostic category of patient are gathered each month.