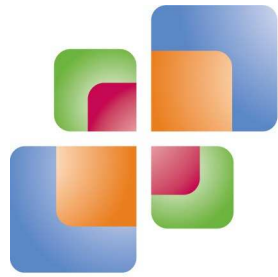


National Rehabilitation Hospital



NRH

**National
Rehabilitation
Hospital**

Brain Injury Programme Scope of Service

Contents:

Introduction	3
Inpatient Rehabilitation	6
Outpatient Rehabilitation	13
Home and Community Based Rehabilitation (including Vocational Services)	21
Appendices	28



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. 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)

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, 119 bed inpatient and outpatient rehabilitation hospital located in South Dublin suburb of Dun Laoghaire.

INPATIENT REHABILITATION (BI/IP)

The BI/IP is a 46 bed inpatient brain injury rehabilitation programme. BI/IP service areas are located throughout the hospital. Patients admitted to the BI/IP stay in one of four wards. Each ward serves persons with different levels of assessed need. The BI/IP also has three beds that are dedicated to persons with ABI in a minimally conscious/low arousal state. The four BI/IP wards are:

- St. Patrick's ward. This is a secure 9 bed ward that consists of 2 individual rooms and 7 cubicles. The ward has individual therapy, dining and TV and recreational areas. There is video surveillance of all patient areas.
- St. Brigid's ward. This is a 22 bed ward that includes one large 19 bed ward, 2 single rooms and a single cubicle. The ward also has two rooms available for group or individual treatment or meetings.
- St. Camillus' and St. Gabriel's wards. These wards combined offer 15 brain injury beds that include 4 individual rooms, 3 with ensuite. St Camillus' and St Gabriel's wards are male and female only wards respectively.

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 (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.
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 outpatient, community or home rehabilitation setting.
 4. Have the potential to benefit from specialised inpatient rehabilitation through the utilisation of an interdisciplinary team approach within a specified time-frame.
 5. Be under the care of a National Rehabilitation Hospital Medical Rehabilitation Consultant.

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.

Discharge Criteria:

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

1. The person has received 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.
 6. The person is non-compliant 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.

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.

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

In some instances the person served can be in receipt of services from multiple programmes within the NRH and also linked services at NRH throughout their programme of care. For example, a person who has experienced a brain injury may also have a spinal 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.

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
- 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, informal 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 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.

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 maybe 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).

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 has 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 admission to the BI/OP.

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.

Table 1: NRH Brain Injury Programme Outpatient Clinics

Brain Injury Clinic	
Linked Clinic	

Day	Time	Frequency per month	Name of clinic	Consultant / Clinic lead	Clinics arranged by:
Monday	9.00-13.00 14.00-17.30	1 st Monday	Neurobehavioural Clinic	Dr. Delargy Dr. O'Driscoll Dr. Simone Carton	Claire Nolan 01 235 5552
Monday	9.00-13.00	4 th Monday	Brain Injury Multi disciplinary New	Dr M Delargy	Claire Nolan 01 235 5552
Monday	13.30-16.30	2nd Monday	Brain Injury Multi-disciplinary New	Dr. A. Carroll	Claire Nolan 01 235 5552
Monday	9.00 - 12.00	Weekly	Brain Injury Consultant Led New & Review	Dr. McElligott	Lorna Byrne 01 235 5389
Tuesday	9.30 - 13.00	Weekly	Brain Injury Consultant Led New & Review	Dr J Morgan	Claire Nolan 01 235 5552

Tuesday	13.30-16.30	2 nd & 4 th Tuesday	Brain Injury Consultant Led Review	Dr. A. Carroll	Amy Harris 01235 5274
Tuesday	15.00-16.00	2 nd & 4 th Tuesday	Paediatric Clinic	Dr. H. Monaghan	Angela Browne 01 235 5331
Wednesday	14.00-16.00	1 st Weds of Month	Orthopaedic Clinic	Mr. K. Synnott	Wendy McKean 01 236 5277
Thursday	9.00-13.00	1 st & 3rd Thurs	Brain Injury Consultant Led New & Review	Dr. M. Delargy	Trish Quinn 01 235 5550
Thursday	9.00 – 13.00 14.00 – 17.00	Alt Thurs	Orthoptics	Dr. Irene Reid	Trish Quinn 01 235 5375
Thursday	15.00-16.00	Weekly	Psychiatry	Dr. C. Denihan	Trish Quinn 01 235 5375
Thursday	13.00-16.00	Two Thursday's per Month	Disabled Drivers Med Board of Appeal	Dr. J. Morgan	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 (Multidisciplinary) 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 at approximately 3 months post-discharge. 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 few 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

Referral Pathway

The Neurobehavioural Clinic (NBC) at NRH is a specialist multidisciplinary assessment and review clinic catering for persons with severe and challenging behaviour resulting from their acquired brain injury. Referrals for NBC are received from the inpatient team at NRH, from Consultant Neurosurgeons, Neurologists and Psychiatrists and from General Practitioners in the Republic of Ireland. Referrals for review are also accepted from Home and Community Based Services (e.g. Acquired Brain Injury Ireland – ABII) where NRH inpatients have been discharged to for follow-up community support.

Clinic Activity

The NBC is a monthly clinic (1st Monday of every month – or Tuesday in the case of Bank Holidays) that runs from 9am to 5.30pm. The Clinic is led by Dr. Mark Delargy (Consultant in Medical Rehabilitation), Dr. Simone Carton (Principal Clinical Neuropsychologist) and Dr. Kieran O'Driscoll (Consultant Neuropsychiatrist). Persons served are given 1 hour appointment slots and attend accompanied by a significant other, often a family member in order to provide collateral information and to elicit the needs of the family/carer. The assessment or review involves a detailed analysis of referral and/or updated information from

stakeholders followed by a comprehensive multidisciplinary assessment involving person and family/carers.

Outcomes/Coordination of Services

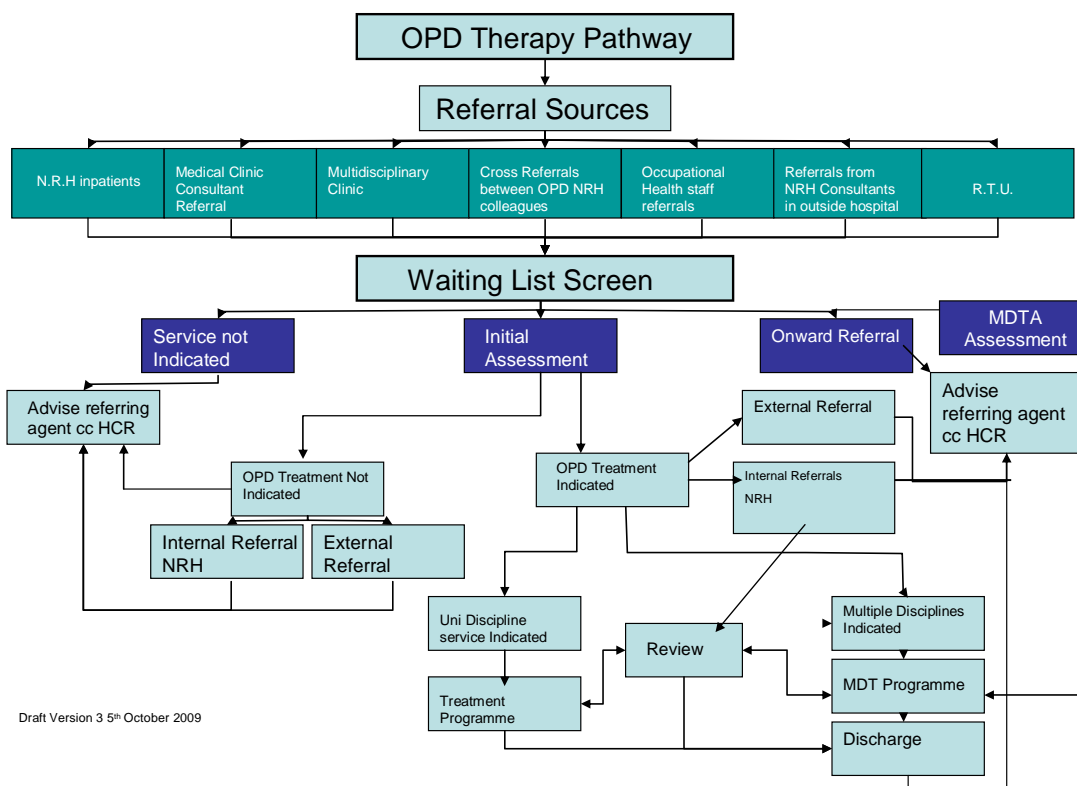
Recommendations including medication management, neuropsychological and behavioural guidelines and ongoing therapeutic input are made on the day. Clinic correspondence (letters and reports) are composed by the 3 lead clinicians and are distributed as widely as possible so that the Referrer and associated care agencies involved with the person receive up-to-date information on recommendations. Medication recommendations or changes are coordinated through the General Practitioner or the Referring Specialist. The NBC also offers follow-up via teleconference. This facility is particularly advantageous for persons with very severe challenging behaviour who are unable to attend in person. In these circumstances the main discussion is with the family members and with the care staff.

Following NBC referrals may also be made to a variety of other services, including the Outpatient Brain Injury Therapy Service at NRH, local Psychiatric services, the Neuroendocrine Clinic at Beaumont hospital and others as indicated.

Outpatient Therapy Service

Referral Pathway

The Outpatient Brain Injury Therapy Service at NRH is for persons who have completed their in-patient rehabilitation at the hospital and/or persons who are referred and deemed suitable by the Brain Injury (New & Review) Clinic for specialist outpatient medical rehabilitation (see Figure 1 below).



The Outpatient Brain Injury Therapy Service includes a wide range of disciplines (outlined below). The need for particular disciplines for each person served is determined by the assessment of the person's individual medical and rehabilitation needs. Outpatient Brain Injury Therapy members could include:

- Clinical neuropsychologist
- Clinical psychologist
- Discharge liaison occupational therapist
- Dysphagia therapist
- Medical Social worker
- Occupational therapist
- Physiotherapist
- Rehabilitation medicine specialist
- Rehabilitation nurse
- Speech and language therapist

Therapy Activity

Following screening assessment, the Outpatient Therapy team offer persons a single, multi or inter-disciplinary service. Outpatient therapy is also specialised,

coordinated, goal directed and outcomes focused rehabilitation. It is an important part of the NRH Brain Injury Programme continuum of care.

Persons served can expect to wait up to 6 weeks following referral to the Outpatient Therapy Service. Appointment times are scheduled with individual therapists and agreed with the person and their family/carer. 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 Outcomes and Environments

The BI/OP aims to discharge all persons served after they have achieved their rehabilitation goals and received maximum benefit from outpatient services. The BI/OP strives at all times to discharge patients at their desired levels of functional independence, social participation and community reintegration and if appropriate facilitate referral to further necessary community rehabilitation and home supports.

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, 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.

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 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.

Rehabilitation Setting

The Next Stage programme is able to facilitate up to 20 full time equivalent trainees. The unit has a training resource room, computer room, conference room, kitchen, manager’s office, counselling 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 rooms offer accommodation to all levels of ability. 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 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 3-6 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 received 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 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.
5. 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 and prescription
- 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. 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:

- Clinical psychologist
- Counselling psychologist
- Education support facilitator
- Medical Social worker
- Occupational therapist
- Physiotherapist
- Rehabilitation medicine specialist
- Training facilitator
- Training manager
- Speech and language therapist
- Sports therapist

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, Peter Bradley Foundation 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.

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.

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) 2nd Monday each month
- Dr. McElligott's Clinic (Spasticity Management) - 3rd Monday each month
- Dr. Delargy's Clinic (Brain injury)- 4th 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.

Note: Patients must remain under the care of the NRH referring consultant for the duration of their therapy programme at the NRH. Medical follow up review should be available for these patients if requested by the therapy team. It is acknowledged that therapy is offered in the team framework and support service must be 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 referrers 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 Rehabilitation 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 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.

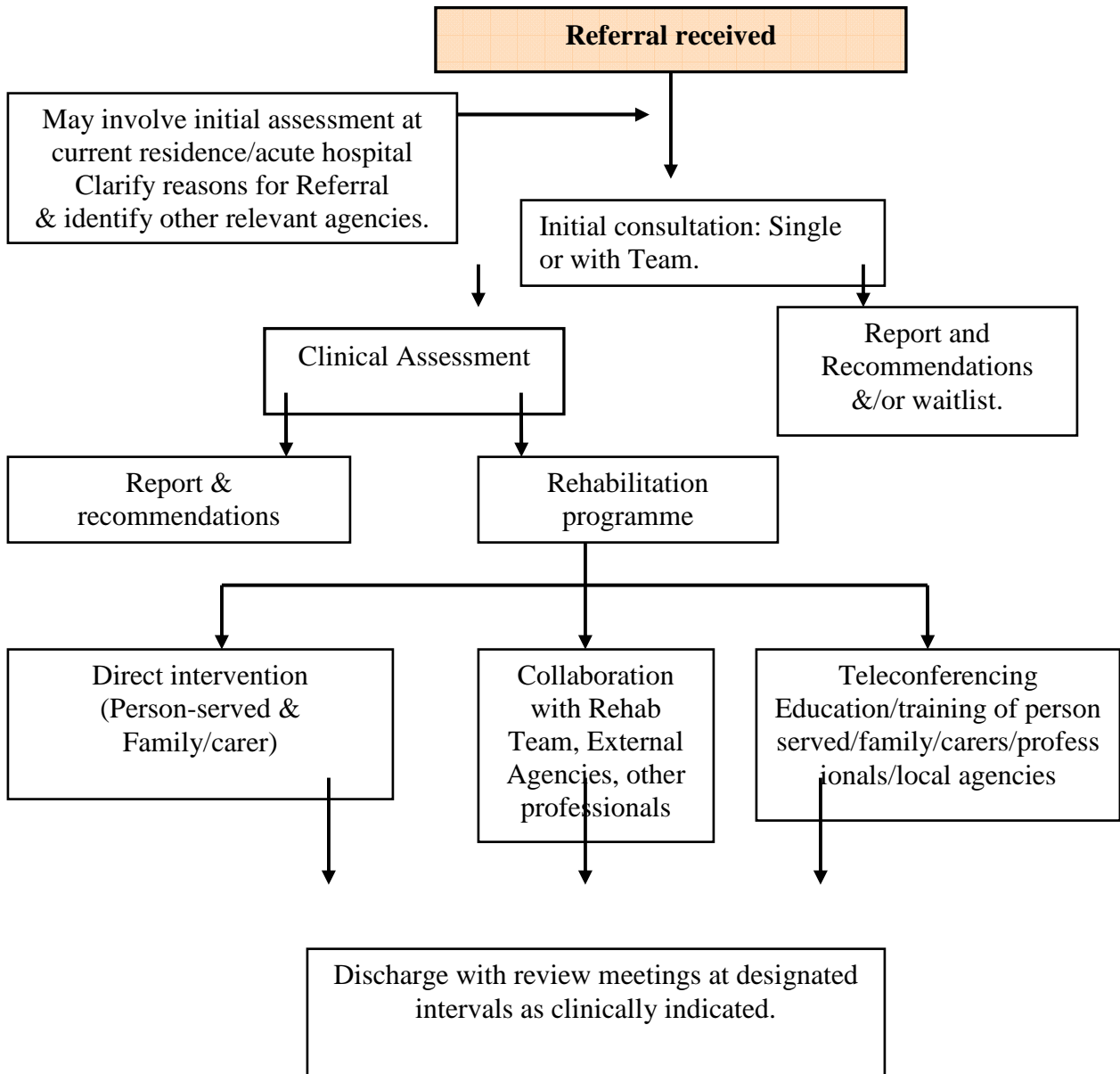
The number of such referrals from the Spinal Programme is approximately 8 per year and from the Polar Programme 6 per year.

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 put onto a waiting list by the Secretary at the Psychology Department. 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:

1. An acquired brain and or spine injury and or limb loss and have cognitive, emotional and or behavioural needs related to this diagnosis.
2. Have the potential to benefit from psychological input.
3. 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:

1. Persons served who have a congenital diagnosis
2. Persons served whose primary diagnosis is psychiatric e.g. Conversion disorder, Borderline personality.
3. 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:

1. The person served has achieved his/her goals as agreed at preliminary assessment.
2. It emerges during the assessment and or intervention that the person's goals and needs can be better met with another agency or service.
3. 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.
4. The persons served capacity to continue to benefit and or achieve his/her goals has reached a plateau.
5. 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 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 2nd Monday of the month
Dr Delargy brain injury clinic 4th and 5th 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. There is a referral form, which is on NRH common, or a referral letter is accepted.
- 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 on a first come first served basis. 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, usually on a weekly basis, with their goals reviewed after 10-12 weeks
- 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
11. Supportive caregiver or family network

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
- A plan is outlined to 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

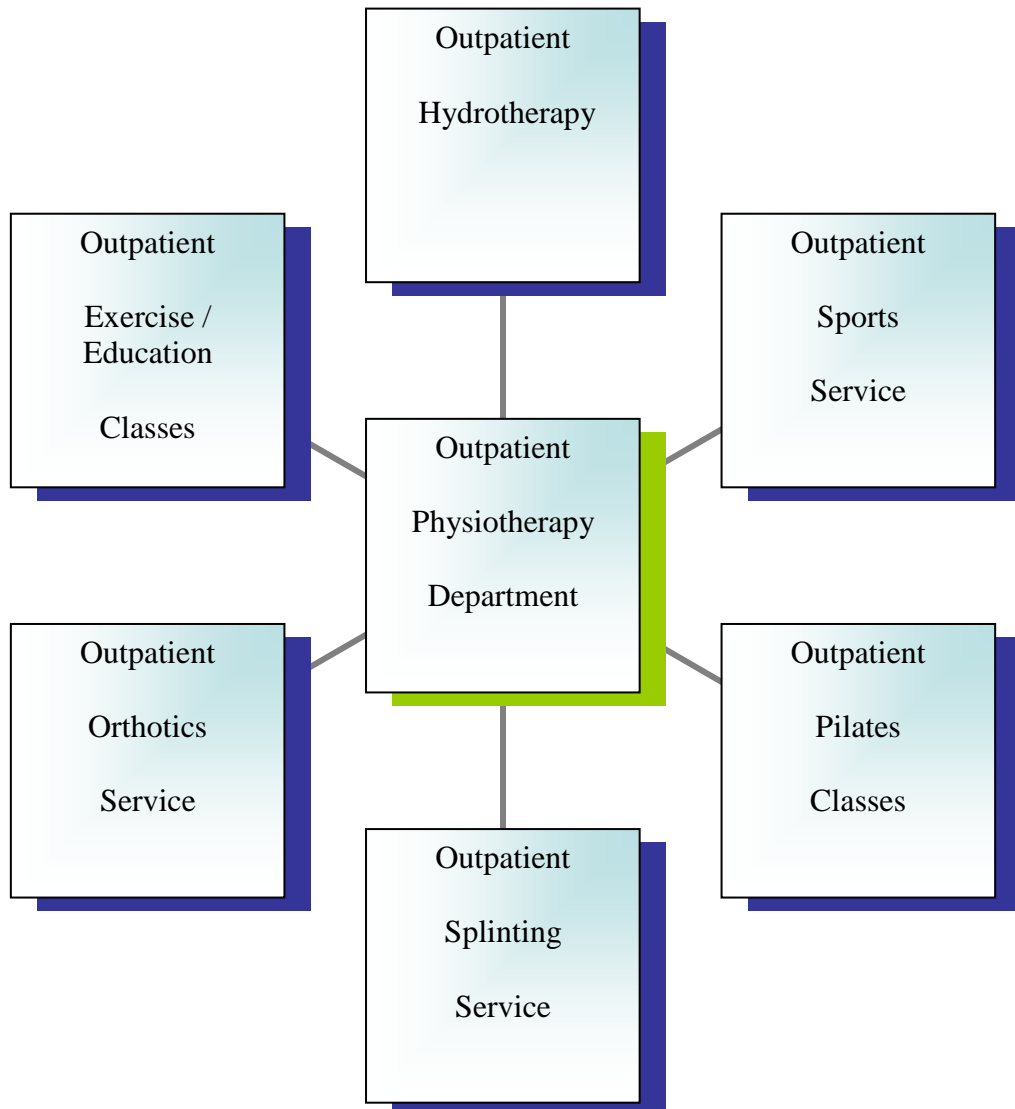
The waiting list is held in the OPD Common folder.
Service development meetings are held twice monthly

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

- 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 on a first come first served basis 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.

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 patients 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

1. Persons served whose primary diagnosis is psychiatric e.g. Conversion disorder, Borderline personality although the family may be seen for advice/onward referral
2. 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:

1. The person served has achieved his/her goals as agreed at preliminary assessment.
2. It emerges during the assessment and or intervention that the person's goals and needs can be better met with another agency or service.
3. 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.

4. The persons served capacity to continue to benefit and or achieve his/her goals has reached a plateau.
5. 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.