National Rehabilitation University Hospital

National Rehabilitation Hospital

Brain Injury Programme
Scope of Service

2020

Contents :

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, (e.g. 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.

In Ireland, there are no official statistics for the number of people living with an acquired brain injury. However, 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. Additionally, it is estimated that there are up to 30,000 people in living in Ireland 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 Programme 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.
- Brain Injury Outpatient Rehabilitation Programme.
- Brain Injury Home and Community Based Rehabilitation Programme.
- Brain Injury Vocational 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 lifelong process.

Rehabilitation Setting

The National Rehabilitation Hospital (NRH) is a publicly financed, voluntary, free-standing, 120 bed inpatient and outpatient rehabilitation hospital located in the south Dublin suburb of Dun Laoghaire.

INPATIENT REHABILITATION

The programme delivers a 40-bed inpatient acquired brain injury rehabilitation programme with sub-specialties listed below:

- Prolonged Disorders of Consciousness (PDoC - 5 beds in a cohort specialist unit)
- Neuro-behavioural Programme (NB - 3 beds in a cohort secure unit)

Inpatient programme areas are located throughout the hospital across five units spread over three floors of the hospital. Each unit has a consultant led interdisciplinary team, comprising of non-consultant hospital doctors, rehabilitation nursing, physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, medical social workers, who act as case coordinators, and creative arts therapists. Each of the units serves patients with mixed complexity levels from ranging from low to high and determined by the Rehabilitation Complexity Scale – Extended (RCS-E).

Hours of Service

The inpatient programme provides 24-hour, seven-day-a-week medical and nursing care with therapy and ancillary care provided 5-days-a-week (Mon-Fri).

Exclusion Criteria:

Persons with ABI are excluded from the inpatient programme 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 inpatient programme 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 (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 psychological needs related to the acquired brain injury or disease process.
2. Be aged 18 or over at admission. In the case of 16-18 years, patients can be admitted in consultation with the NRH Paediatric and Family Centred Programme and where a full pre-admission risk assessment and care plan in line with the NRH Child Protection Policy has been completed.
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.
5. Be under the care of a National Rehabilitation Hospital Consultant in Rehabilitation Medicine.
6. 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, arrangements such as application for high support packages may need to be made prior to the admission to the programme.

Access to the inpatient programme may include:-

- Consultation by a Consultant in Rehabilitation Medicine
- IDT assessment and recommendation

- Advice from a specialist neuro-rehabilitation team on equipment or self-management strategies
- Recommendation to health and social care professionals on treatment options
- Onward referrals to other agencies

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

The Brain Injury Programme operates a waiting list management system which is monitored by a multi-disciplinary group to ensure that all administrative, managerial and professional health care staff follow an agreed minimum standard for the management and administration of the patients on the list in adherence to national waiting list policy.

Discharge Criteria:

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

1. The person is deemed to have achieved their identified goals for their admission and therefore 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. Where the anticipated achievement of goals has not been possible, it may be determined that 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 the inpatient programme has admission criteria the NRH (as a publicly funded organisation) does not operate a denial of services. In response to any referral there is an assessment of eligibility for the programme. 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 inpatient programme, the person will receive a comprehensive preadmission assessment in order to identify their rehabilitation 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 inpatient programme 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 inpatient programme admission criteria, they may be offered an admission.

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 inpatient programme receive a minimum of two hours of direct rehabilitation nursing and/or 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 gradual reintegration for the person into these environments.

Services offered in the inpatient programme to meet identified needs could include:

- Activities of daily living (ADL) assessment and training
- Adaptive equipment assessment and training
- Aquatic Physiotherapy
- 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
- 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
- Sports and Exercise Physiotherapy
- 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, Neuropsychiatry and Orthopaedics
- On road driving assessment and training
- Optician
- Osteoporosis assessment
- Podiatry
- Substance abuse counselling
- Flexible Endoscopic Evaluation of Swallowing (FEES)

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

People with ABI in the inpatient programme 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:

- Art Therapist
- Brain injury liaison coordinator
- Brain Injury preadmission coordinator
- Chaplain
- Clinical neuropsychologist
- Clinical psychologist
- Dietitian
- Discharge liaison occupational therapist
- Health care assistants
- Aquatic Physiotherapist
- Medical Social worker
- Music Therapist
- Occupational therapist
- Pharmacist
- Physiotherapist
- Psychiatrist
- Radiologist
- Recreation Therapist
- Rehabilitation medicine specialist
- Rehabilitation nurse
- Speech and language therapist
- Sports and exercise physiotherapist

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 inpatient programme 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.
- Pastoral and spiritual services

- Peer support through interaction with other families and various community support groups (e.g. Acquired Brain Injury Ireland and Headway Ireland).
- Information about community support, advocacy, accommodation and assistive technology resources.

Discharge Outcomes and Environments

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

Alternative discharge destinations such as long-term care facilities, assisted living residences, group homes or other 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 programme strives to deliver goal orientated rehabilitation for all patients who require rehabilitation services. However, it is recognised that in some instances active rehabilitation is not the most appropriate or suitable approach for the patient and/or their family. In such cases, with the consent of the patient and/or in consultation with their family or legal representative, the programme can offer referral to Palliative Care services. The programme 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

Brain Injury Outpatient rehabilitation 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 an open treatment area for functional therapies located in this building, which includes appropriate equipment and treatment cubicles.

Hours of Service

The outpatient programme provides five days-a-week (Monday to 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 outpatient programme 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 outpatient 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 (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 psychological needs related to the neurological injury or disease process

2. Be aged 18 years or over at time of admission.

3. Have identified medical, cognitive, physical, communication and/or psychological 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 timeframe.

5. Be under the care of a National Rehabilitation Hospital Consultant in Rehabilitation Medicine.

6. Have access to their own transportation to/from the outpatient programme.

Activities provided to such patients may include:

- Consultation by Consultant in Rehabilitation Medicine
- Single Discipline or Multi-Discipline Team assessment
- Advice from specialist neuro-rehabilitation team on equipment, self – management strategies etc.
- Review and identification of specific issues for intervention
- Recommendation to health and social care professional colleagues on treatment programme
- Onward referral to other agencies
- Redirection 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, other OPD services, RTU etc).

Admission to the outpatient programme is based on the preadmission rehabilitation 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. Furthermore, the timing of admission to the outpatient programme may be influenced by the preadmission assessment of the specificity, intensity of the individual's needs and level of dependency, in relation to programme's capacity to best meet these specific needs at that time.

Discharge Criteria:

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

1. The person is deemed to have received achieved their identified goals for their programme and therefore received maximum benefit from the 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 outpatient programme, 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 programme 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 outpatient programme admission criteria, they may be offered treatment by the multidisciplinary team.

Following admission, the relevant outpatient programme 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.

HOME AND COMMUNITY BASED AND VOCATIONAL SERVICES

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 trainee 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 transdisciplinary 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 bed and breakfast style accommodation in Corofin Millennium Lodge.

The Corofin Millennium Lodge is an 11-bedded residential facility located above the Rehabilitative Training Unit. It has twin, single, carer and high dependency rooms 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. cerebral anoxia
        iii. other toxic or metabolic insult (e.g. hypoglycaemia)
        iv. 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 trainees.

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.
5. The person is no longer willing to be an active participant in the inpatient programme. (The Next Stage programme is strictly voluntary, and persons can request to discontinue their programme at any stage)
6. 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 trainees 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 trainee that will liaise with the trainee/family and also establish goals and outcomes with the trainee. After this induction period, the transdisciplinary team members, in collaboration with the trainee 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. Trainees 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. Trainees 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. Aquatic physiotherapy and sports/exercise)
- Medical assessment and management
- Speech & Language Therapy
- Medical speciality consulting including Psychiatry, Neuro-ophthalmology, Neuropsychiatry.
- 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 caseworker is being assigned to each trainee. The composition of the NRH/RTU transdisciplinary 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
- IT instructor
- Education support facilitator
- Occupational therapist
- Rehabilitation medicine specialist

- Speech and language therapist
- 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 lifelong 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. 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 'Woodpark', our short stay independent living facility

Each trainee is assigned their own caseworker at time of induction. The caseworker 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 trainees are encouraged to avail of any further support services that we identify for them in their locality e.g. Vocational and Educational College services, SOLAS education and training boards, and the National Learning Network.

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.