National Rehabilitation Hospital

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Brain Injury Programme

Scope of Service

2024

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National Rehabilitation Hospital

Introduction:

The Brain Injury Programme (BIP) of rehabilitation at the National Rehabilitation Hospital (NRH) provides specialised, co-ordinated interdisciplinary, person-centred, outcomes focussed rehabilitation for individuals 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 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 ABI is defined as any sudden injury to the brain sustained during a person's lifetime and not as a result of birth trauma. An ABI may be caused by trauma, tumour, ischaemia, haemorrhage, anoxia, toxic or metabolic insult (e.g. hypoglycaemia), infection (e.g. meningitis, encephalitis) or inflammation (e.g. vasculitis). Every injury is unique, meaning that symptoms can vary widely according to the location and extent of the injury to brain tissue. The impairments arising from ABI can affect many domains, including medical status, physical ability, cognition, communication, behaviour, psychological status and social skills.

As a result, affected individuals may have reduced ability 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 ABI. However, by extrapolating data from other countries to the Irish population, it is estimated that between 9,000 and 11,000 people sustain a traumatic brain injury annually in Ireland. Furthermore, it is estimated that up to 30,000 people are living in Ireland with long term difficulties following ABI.

Under the direction of the BIP 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.

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 referral to 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- Rehabilitation Training Unit (RTU).

This comprehensive, interdisciplinary continuum of care ensures that all individuals can receive the most appropriate programme of care based on 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 may receive input from multiple NRH programmes and services throughout their continuum of care. For example, a person with a brain injury may also have a spinal cord injury or limb amputation. This “dual diagnosis” requires a specialised and individualised treatment plan that addresses the person’s specific needs 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 and are encouraged to participate in all aspects of the programme. Information, education, counselling, emotional and psychological support have 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 Dun Laoghaire, Co. Dublin.

Inpatient rehabilitation

The programme delivers a 40-bed inpatient acquired brain injury rehabilitation programme with a sub-specialty of Prolonged Disorders of Consciousness (PDoC - 5 beds in a cohort specialist unit).

Inpatient programme areas are located throughout the hospital across four units. 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 serve 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 6-days-a-week (Mon-Sat).

Exclusion Criteria:

Persons with ABI are excluded from the inpatient programme where other needs (for example, medical, psychiatric, behavioural, 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 may be made to the referring agent regarding other more appropriate services at that time. Persons are excluded where they are not deemed to demonstrate the admission criteria e.g. they do not have had damage to their brain tissue. This includes Functional Neurological Disorders (FND).

Admission Criteria:

To be admitted into the BIP 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, for example:
        i. Trauma
        ii. Haemorrhage
        iii. Ischaemia / infarction
        iv. Anoxia/hypoxia
        v. Toxic or metabolic insult (e.g. hypoglycaemia)
        vi. Infection (e.g. meningitis, encephalitis)
        vii. Inflammation (e.g. vasculitis).
        viii. Brain tumour
        ix. Other
    b. Have medical, cognitive, physical, communicative and/or psychological needs related to the ABI or disease process.
2. 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, comprehensive discharge planning needs to have commenced including arrangements such as application for high support packages and long-term care planning need to be made prior to the admission to the programme.
3. Be aged 18 or over at admission. Individuals aged 16-18 years may 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.
4. Have identified medical, cognitive, physical, communication and/or behavioural needs which cannot be met in an outpatient, community or home rehabilitation setting.
5. Have the potential to benefit from specialised inpatient rehabilitation using an interdisciplinary team approach.
6. Be under the care of a Consultant in Rehabilitation Medicine.
7. Patients who have accessed another rehabilitation service within the managed clinical rehabilitation network (MCRN) and have had their needs met will not be admitted unless they require a specific service in the NRH that is not available within another service in the network e.g. vocational rehabilitation or their condition has changed.

Pre-admission care may include:-

- Consultation by a liaison Consultant in Rehabilitation Medicine from the NRH are currently available in MMUH, SVUH, Beaumont, Tallaght and St. James Hospitals. Consultation in other sites may be sought and can be provided in certain circumstances.
- Outreach assessment and recommendation for patients with severe brain injury and in PDoC.

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 and readiness for rehabilitation, 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 in line with to National Inpatient Waiting List Management Protocol and NRH Referrals Management 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 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
- Art Therapy
- Assistive technology assessment and training
- Audiology screening
- Behavioural assessment and management
- Bowel and bladder training
- Clinical neuropsychological assessment
- Cognitive assessment and rehabilitation
- 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
- Flexible Endoscopic Evaluation of Swallowing (FEES)
- Independent living skills assessment & training
- Medical assessment and management
- Mobility assessment and training
- Music Therapy
- Nutritional counselling and management
- Ophthalmology
- 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
- Psychiatry
- 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
- Wheelchair and seating assessment

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 ABI. 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 outreach specialist
- Brain Injury rehabilitation coordinator
- Chaplain
- Clinical neuropsychologist
- Clinical psychologist
- Dietitian
- Discharge liaison occupational therapist
- Health care assistants
- Medical Social worker
- Music Therapist
- Occupational therapist
- Pharmacist
- Physiotherapist
- Phlebotomy
- Psychiatrist
- Radiologist
- Recreation Therapist

- Rehabilitation medicine specialist
- Rehabilitation nurse
- Speech and language 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.

Pharmacy Service

On-site services to inpatients:
Pharmacy services are available onsite, during normal working hours Monday- Friday. The pharmacy purchases and dispenses medications for all inpatients, in a timely manner throughout their stay in the NRH. Medications are also dispensed for therapeutic leave and discharge. Medications are reviewed and optimised, in consultation with the medical staff and person, throughout the persons stay. Medication education is provided in group and individual sessions according to persons requirement.

Capacity

There is capacity to respond to all pharmacy requests according to clinical need, as requested by the referring medical doctor including weekends.

Timeliness of response to Order:
Urgent requests for medication are prioritised to be provided on a same day basis, Monday to Friday, 9-5 and via the Nursing Manager in charge at weekends.

Diagnostic Imaging

On-site services to inpatients:

- X-ray service, portable and in the Radiology Department, during normal working hours and after hours on an on-call basis, based on clinical need 24/7.
- Ultrasound (US) service, both in the Department and portable, 9-5, Monday to Friday.
- DXA service in the Radiology Department, 9-5, Monday to Friday.

Off-site Diagnostic imaging:

- CT imaging service at St Columcille's Hospital, Loughlinstown, Monday to Friday 9-5, on an urgent and elective basis, depending on clinical need, by NRH ambulance transfer.
- Video fluoroscopy is available at St. Columcille's Hospital and the Beacon Hospital as required.
- MRI service by arrangement with private providers on a scheduled basis.

Capacity:

There is capacity to respond to all requests for urgent and scheduled diagnostic imaging according to clinical need, as requested by the referring medical doctor.

Timeliness of response to Order:
Urgent requests for imaging are prioritised to be carried out on a same day basis, Monday to Friday, 9-5. In addition, urgent X-ray is also provided out of hours by the on-call radiographer as requested by the medical team. There are no waiting lists for elective diagnostic imaging, which is scheduled to suit individual patient's needs and availability.

Timeliness of results to the clinician who is making a decision based on those results:
Urgent results are provided electronically within 24 hours by the reporting Consultant Radiologist by remote access via the National Integrated Medical Imaging System (NIMIS). Reporting of elective/scheduled imaging is carried out when the Radiologist is on site twice a week. The Radiology Department participates in the National Radiology Quality Improvement Programme which includes timely communication of critical, urgent and unexpected and clinically significant radiological findings via an electronic alert management system in line with specified national guidelines.

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 Woodpark transitional independent living facility.
- Pastoral and spiritual services
- Peer support through interaction with other families and various community support groups
- 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 provides complex, specialist rehabilitation to patients with acquired brain injury. The main Outpatient Department is located on the grounds of the NRH in Unit 6. Patients attending the Brain Injury Outpatient Rehabilitation programme access specialist neurorehabilitation services to target to specific, person-centred goals.

Hours of Service

The outpatient programme provides six days-a-week (Monday to Sat), 9am to 5pm. 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.

Patients will be excluded from NRH OPD services if NRH cannot provide the service requested. NRH OPD team is currently unable to provide:

- Wheelchair Prescription and Provision
- Home and Environmental Assessments
- Discharge Liaison OT services
- Dietetic input

Admission Criteria:

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

1. Have the following:
    a. Acquired brain injury (ABI) is an inclusive category that embraces acute (rapid onset) brain injury of any cause, for example:
        - Trauma
        - Haemorrhage
        - Ischaemia / infarction
        - Anoxia/hypoxia
        - Toxic or metabolic insult (e.g. hypoglycaemia)
        - Infection (e.g. meningitis, encephalitis)
        - Inflammation (e.g. vasculitis).
        - Brain tumour

        i. Other
    b. Have medical, cognitive, physical, communicative and/or psychological needs related to the neurological injury or disease process that require complex, specialist rehabilitation.

2. Be aged 18 years or over with the exception of the Paediatric Transition Clinic Reviews which are run by the Paediatric Team. This is a service for patients who are moving from the paediatric to adult service.

3. Have the potential to benefit from complex, specialised outpatient rehabilitation.

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

5. Have access to their own transportation to/from the outpatient programme if in-person appointments are required.

Activities provided to such patients may include:

- Medical Consultant clinics e.g. Doctor only clinics.
- Interdisciplinary Clinics e.g. assessments with a Medical consultant and therapy team, Neurobehavioral Clinics.
- Nursing assessments and reviews including the Sexual Health and Wellbeing service.
- Ophthalmology and orthoptic clinics.
- Speech and Language Therapy
- Occupational Therapy including Vocational Assessment.
- Physiotherapy.
- Psychology
- Medical Social Work.
- Orthotics and Splinting.

Input from the OPD Therapy team may include single or interdisciplinary assessment and intervention, consultation and advice or group therapy.
Some of our therapy groups include: Graded Repetitive Arm Supplementary Programme (Grasp) Group, Living with Aphasia group, Pilates, Wellness Programme

- Onward referral to other agencies.
- Redirection and recommendations regarding appropriate agencies if needs cannot be met at NRH Brain Injury OPD Department.

Driving:

The NRH Outpatient department currently has a very limited resource for driving assessments. At present, these assessments are only available to previous NRH inpatients and to NRH outpatients who are completing a full outpatient rehabilitation programme and who present with cognitive and/or visual perceptual difficulties. We are currently unable to offer driving assessments to patients who do not require other NRH Outpatient Services or who present with physical impairments only. Patients who require a stand-alone driving assessment can contact the Irish Wheelchair Association or Transport and Mobility Consultants Ireland to explore alternative driving assessment options.

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. The NRH Outpatients department operates a waitlist management system in adherence with the National Outpatient Waitlist Protocol.

Discharge Criteria:

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

1. The person has achieved their identified goals for their programme.

2. The person has improved to the projected functional level that will allow discharge to another 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 cancels or does not attend their appointments in line with the NRH DNA and CNA policy.

8. 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 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.

The Home & Community Programme at the Rehabilitative Training Unit (RTU)

The home and community programme

Scope of service 2024

The Home & Community Programme at the Rehabilitative Training Programme (RTU) at the National Rehabilitation Hospital (NRH) provides specialised, interdisciplinary, coordinated and individualised outcomes focused rehabilitation for people with acquired brain injury (ABI). It is part of the NRH Brain Injury continuum of care.

The RTU is a national rehabilitative training service provider accepting referrals of persons with an ABI residing in Ireland. The programme is designed to assist people with an 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 skills. The programme also refers persons served to appropriate health, support or community services to facilitate and implement these goals. The person served attending the RTU is called an RTU Trainee and these terms are used interchangeably in this document.

Main Aims of the Next Stage Home & Community Programme

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

The Home & Community 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 person-centred format by providing a high-quality and individualised training programme. The necessary qualifying factor for entry is that applicants show sufficient insight to enable attendance, ability to identify training goals, potential and motivation to move on to their own next stage.

The services of the RTU 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 to 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 and the community.

This comprehensive interdisciplinary system of continuum of care ensures that all trainees 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 RTU programme facilitates up to 17 whole-time equivalent trainees. The Unit has a reception area, training resource room, computer room, conference room, kitchen, manager's office, counselling room, individual treatment room and a general office.

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

The Corofin Millennium Lodge is an 8-bedded facility located in the RTU building. It has single en-suite rooms and can offer accommodation to various levels of ability (PA required for trainees who require assistance with their activities of daily living/ personal care). 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 Thursday 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 (max 30-hour week)

Hours: 9.30 am to 5.00 pm; Monday to Thursday
9.30 am to 1.00 pm; Friday
Closed Saturday
Corofin Lodge opens Sunday evenings (6.00 pm)

The average programme duration is currently 12 months, ranging from 3 months to 18 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 engagement with other services. During 2023 the programme was delivered on -line on two platforms, MS Teams and Attend Anywhere. Attendance was both in-person and online, delivering a hybrid training programme.

Admission Criteria:

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

1. Have one of the following:
    c. Acquired brain injury or disease (ABI), which is an inclusive category that embraces acute (rapid onset) brain injury of any cause, for example:
        x. Trauma
        xi. Haemorrhage
        xii. Ischaemia / infarction
        xiii. Anoxia/hypoxia
        xiv. Toxic or metabolic insult (e.g. hypoglycaemia)
        xv. Infection (e.g. meningitis, encephalitis)
        xvi. Inflammation (e.g. vasculitis).
        xvii. Brain tumour
        xviii. Other
    d. Have medical, cognitive, physical, communicative and/or behavioural needs related to the neurological injury or disease process.
8. Be aged 18 years at time of admission.
9. Have the potential, and level of insight, to develop greater functional independence and to actively participate in group training. Be able to arrange own transportation to/from the RTU
10. Be independent in their personal activities of daily living, or have carer/ PA.
11. Be able to co-operate and work with staff and other trainees.
12. Be under the care of an NRH Consultant in Rehabilitation Medicine.

Admission to the Next Stage programme is based on the referral information, meeting admission criteria, and outcome of the initial intake interview. The timing of admission to the programme is approximately 7 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 person. This includes Functional Neurological Disorder (FND). 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 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 served 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 persons served, types of services offered, outcomes, and any other programme 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 a Trial Programme, during which is the induction period. During the induction period, a caseworker will be assigned to the person served that will liaise with the client/family and establish foundation goals and outcomes with the person served. After this induction period, the interdisciplinary team members, in collaboration with the person served and their family/support network, will develop a comprehensive Individual Training Plan (ITP) that addresses the identified goals of the person served and their family/support network. This ITP is reviewed with the person served every 6-8 weeks, and caseworker meetings are scheduled on a regular basis to support goal attainment. The person 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 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
- Discharge Planning

Furthermore, if additional services are required the programme can facilitate referral to certain ancillary services.

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

- Medical assessment and management
- OPD Physiotherapy Services
- OPD Speech & Language Therapy
- Smoking cessation support
- Sexuality & Wellbeing Service
- Therapeutic Recreation
- Social Prescribing
- Pastoral and spiritual guidance
- OPD Medical speciality consulting including Psychiatry/ Neuro-ophthalmology/ Neuro-psychiatry
- OPD Occupational Therapy
- Driving assessment
- Community based PCC/ Substance abuse counselling

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

- Counselling psychologist
- Education support facilitator
- Occupational therapist
- Rehabilitation medicine specialist
- Training facilitator
- Information Technology instructor
- Exercise therapist
- 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 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 supports, Trainee progress within the service, advocacy, accommodation, and assistive technology resources.
- Annual events for families, including Family Information Day (for families on the waiting list) and Family Education Day (for families of current trainees).
- Trial of supported living on site in our short stay independent living facility.
- Each trainee is assigned their own caseworker during the trial period. 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 RTU Home & Community programme aims to discharge all trainees after they have achieved their rehabilitation training goals and received maximum benefit from the programme. The programme strives 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. community rehabilitation network team (CNRT), HSE ABI case coordinator, Headway, Acquired Brain Injury Ireland, Irish Heart Foundation/ Stroke supports, Irish Kidney Association etc.

The RTU has continued over the years to secure excellent outcomes for the trainees of the Home & Community Programme. Acceptable outcomes for our programme include community programmes, volunteering, health gain and/or social gain, community reintegration. Outcomes for RTU trainees are measured using the Mayo Portland Adaptability Inventory; where gains are measured in terms of ability, adjustment and participation.