National Rehabilitation Hospital

Stroke Programme

Scope of Service

2024

Contents :

Introduction:

The Stroke Programme of rehabilitation at the National Rehabilitation Hospital (NRH) provides specialised, interdisciplinary, coordinated and outcomes focussed rehabilitation for people with stroke. The programme demonstrates the commitment, capabilities, and resources to maintain itself as a specialised programme of care for people with stroke.

A Stroke is damage to the brain due to a lack of blood supply or bleeding into the brain. Symptoms last over 24 hours and includes ischaemic stroke (blocked blood vessel) and haemorrhagic stroke (bleeding inside the brain). One of the most important things to know about surviving a stroke is that every stroke is unique, meaning that symptoms can vary widely according to the extent and location of damage to brain tissue. Ensuing impairments can result in a wide range and varying levels of medical, physical, cognitive, communicative, psychological, social, behavioural, vocational, educational, cultural, family, and spiritual and leisure needs in people with stroke. Impairments may also impact the functional abilities of people with stroke to live independently, return to work or education, participate in leisure and social activities, fulfil family roles and maintain personal, sexual and family relationships.

Stroke is a leading cause of death and disability worldwide. In Ireland, approximately 10,000 people will have a stroke event each year. Of these, it is estimated that approximately 2,000 will die and a further 7,000 will require acute hospital admission. There is currently upwards of 30,000 people living in Ireland with disabilities as a result of stroke. Patients who survive a stroke are often left with some level of disability. Rehabilitation to reduce disability is therefore very important for the care of stroke patients.

Under the direction of the Stroke Programme Manager and the Stroke Medical Director, the programme, 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 stroke to achieve their desired levels of functional independence, social participation and community reintegration.

The stroke 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 Stroke Continuum of care.
- Support for information sharing, movement and access with other external stroke 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 stroke within the NRH Stroke Continuum of care

NRH Stroke Continuum of Care

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

- Stroke Comprehensive Integrated Inpatient Rehabilitation Programme (SIP)
- Outpatient Rehabilitation Programme
- Home and Community Based Rehabilitation Programme.
- 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 stroke may also have amputation. 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/support system. 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 South Dublin suburb of Dun Laoghaire.

INPATIENT REHABILITATION

Stroke Inpatient Programme (SIP)

The SIP is a 20-bed inpatient stroke rehabilitation programme. The SIP is located on Willow Unit on the ground floor of the hospital. The unit has a rehabilitation medicine consultant and the programme is delivered by an interdisciplinary team, comprising of non-consultant hospital doctors, rehabilitation nursing, physiotherapy, occupational therapy, speech and language therapy, psychology and medical social workers acting as case coordinators. The unit serves patients with mixed rehabilitation complexity levels from low to very high. Stroke patients can also access the unit that is dedicated to persons with stroke who also present with a prolonged disorder of consciousness (PDoC).

Hours of Service

The SIP 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 stroke are excluded from the SIP 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 may be made to the referring agent regarding other more appropriate services at this 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 SIP at the NRH, the individual must:

1. Have one of the following:
    a. Vascular pathology including:
        i. Ischaemic stroke
        ii. Haemorrhagic stroke
    b. Have medical, cognitive, physical, communicative and/or behavioural needs related to the stroke 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, then this funding for this long-term placement and the location is confirmed prior to the admission to NRH.
3. Be aged 18 or over at admission.
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 through the utilisation of an interdisciplinary team approach within a specified timeframe.
6. Be under the care of a National Rehabilitation Hospital Medical Rehabilitation Consultant.
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 assessment of need and on meeting the programme's admission criteria. However, the timing of admission to the SIP may be influenced by the preadmission

assessment of the specificity, intensity of the individual's needs and level of dependency, in relation to SIP's capacity to best meet these specific needs at that time.

The Stroke 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 SIP at the NRH, one or more of the following must be true:

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

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

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

Services Provided for the Person Served:

Following 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 stroke and secondary prevention related to better management of potential risks and complications.

Persons admitted to the SIP 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 SIP 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

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

People with stroke in the SIP frequently have complex disabilities and subsequently complex rehabilitation needs which require specialist intervention by professionals with knowledge and experience in the management of acquired stroke. 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
- Outreach Specialist
- Rehabilitation coordinator
- Chaplain
- Clinical neuropsychologist
- Clinical psychologist
- Dietitian
- Discharge liaison occupational therapist
- Health care assistants
- Medical Social worker
- Music Therapist
- Occupational therapist
- Pharmacist
- Physiotherapist
- 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 for urgent and scheduled according to clinical need, as requested by the referring medical doctor including weekends.

Timeliness of response to Order:
Urgent requests for medication are rioritized 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 afterhours 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 SIP to meet the needs of the person served and their family/carers including:

- Education/training about management of stroke 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.
- Psychological support services
- Pastoral and spiritual services
- Peer support through interaction with other families and various community support groups (e.g. the Irish Heart Foundation Stroke Services and Headway Ireland).
- Information about community support, advocacy, accommodation and assistive technology resources.

Discharge Outcomes and Environments

The SIP 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 SIP 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 served are prepared for discharge home.

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

Palliative Care

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

Outpatient Rehabilitation

Stroke Outpatient Rehabilitation provides complex specialist outpatient rehabilitation. The main Outpatient Dept is located on the grounds of the hospital in Unit 6. Patients attending the Stroke Outpatient programme access specialist neurorehabilitation services to target to specific, person centred goals.

Hours of Service

The outpatient programme provides 6 days-a-week (Monday to Sat), 9am to 5pm Some services are available outside these times by pre-arranged appointment.

Exclusion Criteria:

Persons with stroke 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 Outpatient services if NRH cannot provide the service requested. NRH Outpatient team is currently unable to provide:

- Wheelchair Prescription and Provision
- Home and Environmental Assessments
- Discharge Liaison OT services
- Access to Lokomat Training
    - Dietetic input
- Flouroscopic Endoscopic Evaluation of Swallowing (FEES)

Admission Criteria:

To be admitted into the Stroke Outpatient Programme at the NRH, the individual must:

1. Have both of the following:
    a. Vascular Accident including:
        iii. Ischaemic stroke
        iv. Intracerebral haemorrhage
        v. Subarachnoid haemorrhage
    b. Have medical, cognitive, physical, communicative, psychological and/or behavioural needs related to the stroke that require complex, specialist outpatient rehabilitation.

2. Be aged 18 years or over at time of admission with the exception of the Paediatric Transition Clinic Reviews which are run by the Paediatric Team.

3. Have the potential to benefit from 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.

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 Stroke 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 changes. 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 Stroke 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 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.

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:
        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
    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.
10. Be able to arrange own transportation to/from the RTU
11. Be independent in their personal activities of daily living, or have carer/ PA.
12. Be able to co-operate and work with staff and other trainees.
13. 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.