

ABI REHABILITATION – SCOPE OF SERVICES

OVERVIEW

ABI Rehabilitation New Zealand Ltd (ABI-NZ) is a private company formed in 1996 to provide a comprehensive range of rehabilitation services for people with traumatic brain injury or other acquired brain injuries e.g. stroke. ABI Rehabilitation has facilities in Auckland and Wellington, providing services to people from throughout New Zealand and internationally as required. The services available include:

- Intensive inpatient rehabilitation
- Acute rehabilitation for minimally conscious clients
- Day rehabilitation
- Slow stream / Long-term rehabilitation (residential care)
- Community and outpatient services.

ABI Rehabilitation provides services under contracts with:

- ACC
- The Ministry of Health (MoH)
- District Health Boards (DHB)
- Private insurers and private funders.

Clinical services are provided under the direction of Rehabilitation Consultants in both Auckland and Wellington.

Our interdisciplinary team is comprised of health care professionals and care workers. The health care professionals include; rehabilitation nursing, physiotherapy, occupational therapy, speech/language therapy, neuropsychology, dietetics and social work. Care is also provided by Rehabilitation Programme Workers (RPW), Client Support Workers (CSW), Rehabilitation programme coordinators (RPC), housekeeping, maintenance and chefs.

ABI Rehabilitation supports the training of health care professionals and workers. We have a range of people in training or completing advanced training in their area of work. This includes:

- Wellington Rehabilitation Consultant who has completed the American board certification in Brain Injury Medicine
- Medical Registrar, (Auckland). This person is completing the Australasian Faculty of Rehabilitation Medicine (AFRM) Training Programme
- Students on placement from nursing, physiotherapy, occupational therapy, speech/language pathology, neuropsychology, dietetics, music therapy and social work
- Staff working on post graduate qualifications
- RPW's, CSW's and Nurses working on career force qualifications.

INTENSIVE INPATIENT PROGRAMME – AUCKLAND AND WELLINGTON CENTRES

ABI Rehabilitation offers comprehensive inpatient therapy services for people aged 16 and over (however with family and case manager approval exception may be made for younger people that are more suited to an adult service). Our goal is to assist the client to attain the highest functional level possible and to enhance their quality of life through the rehabilitation process. The programme is offered seven days per week. This includes Rehabilitation programme coordinators (RPC's) on site 7 days a week, specialist therapy staff available Monday through Friday*, therapy support staff available throughout the week and rehabilitation nurses 24/7.

The intensive inpatient rehabilitation programme is based on the needs of the client. A comprehensive assessment and individualised rehabilitation plan is developed for each client and, where possible, with input from their family/whānau. Based on their rehabilitation needs they will use one or more of the ABI Rehabilitation programmes while in the intensive inpatient programme. The programmes include:

- **Emerging Consciousness Programme**

This is an intensively staffed programme. There is a focus on medical and nursing management, preventing complications, sensory stimulation, early cognitive interventions and family-whānau education and support.

- **Medical and Nursing Rehabilitation Programme**

This programme focuses on early intervention to minimise complications, early cognitive interventions, independence in activities of daily living, and the active involvement of the full Interdisciplinary Team. Staffing is 1:2-3 with 1:1 as required.

- **Neuro-behavioural Rehabilitation Programme**

This programme, led by the neuropsychology and clinical psychology team, is intensively managed by staff with skills in behaviour management and cognitive rehabilitation. Staffing is as required 24/7 including 1:1 management.

- **Community Re-Integration Programme**

This programme provides individualized transitional rehabilitation with a strong focus on involving clients in the community in preparation for returning home, and providing education and support to families.

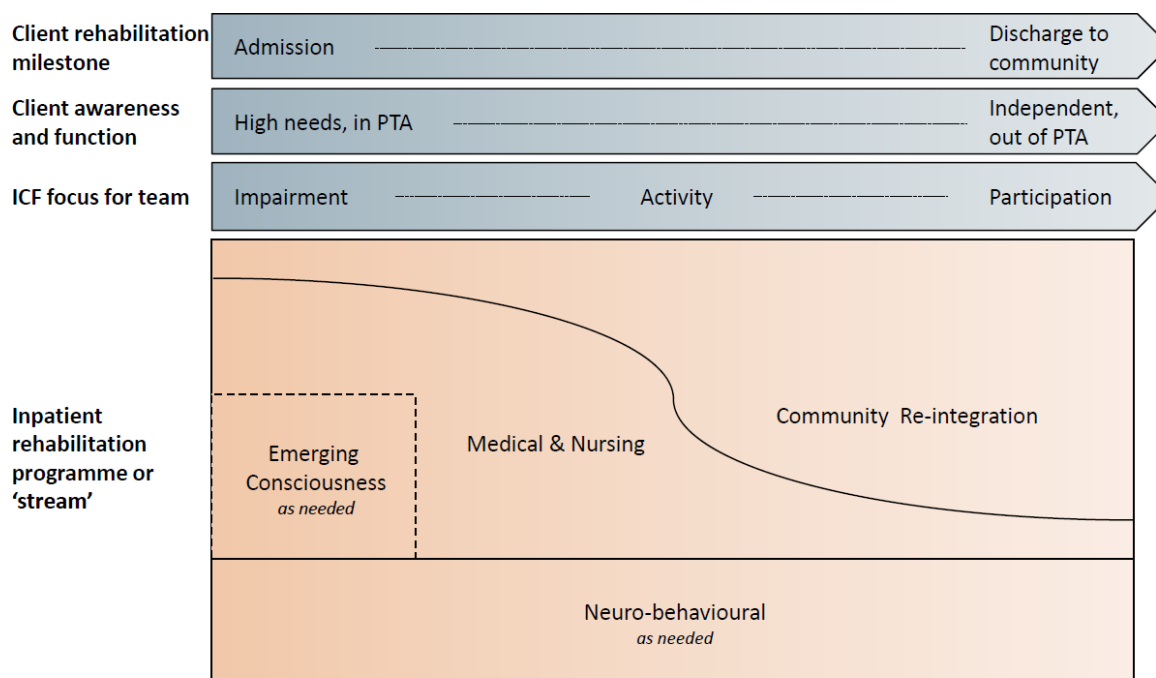
- **Day Rehabilitation Programme**

For clients able to reside at home and live local to the facility, Day Rehabilitation may be a more suitable option. Due to contractual restrictions, this is only available for ACC clients and privately funded clients. Access to therapy input would be the same as if the client was an inpatient.

Written descriptions and brochures of these programmes are available on request.

The diagram below shows the programmes in relation to the:

- Client's rehabilitation progress (milestones)
- Client's awareness and function
- Focus for the team based on the International Classification of Function (ICF).



Each programme is supported by an interdisciplinary team with the following therapy specialties:

- Rehabilitation nursing – on-site 24 hours per day
- Rehabilitation programme workers – on-site 24 hours per day
- Rehabilitation medicine – on-site (Auckland 5 days/ week; Wellington, weekly; on-call 24 hours per day at both sites)
- Rehabilitation programme coordinators/facilitators – on-site Monday through Sunday
- Specialist key- working – on-site Monday through Friday
- Physiotherapy– on-site Monday through Friday*
- Occupational therapy– on-site Monday through Friday*
- Speech language therapy– on-site Monday through Friday*
- Neuropsychology-- on-site Monday through Friday
- Neuro psychiatry –as required
- Clinical psychology- on-site Monday through Friday
- Social work – on-site Monday through Friday
- Recreation therapy – included in the daily programme
- Fitness and exercise training – included in the daily programme
- External specialties are available on an as-required referral basis.
- Chaplain services available
- Other rehabilitation services such as massage, pet therapy and music therapy may also be available.

NB – *Therapy services in Auckland currently include Saturday

REHABILITATION PROGRAMME STRUCTURE

The inpatient rehabilitation programme is structured around a normal day to ensure a balanced approach to life while the client is residing at ABI. The 'work hours' between 08:30 and 15:30 are dedicated to intensive rehabilitation around a structured timetable of medical, therapy and nursing activities. These are built around the goals, strategies and steps that have been agreed with the client and family-whānau.

The 'recreation and social' part of the day is from 15:30 – 20:30. This is less structured but an equally important part of the programme to ensure that the client's social and family relationships are maintained and that there are opportunities to pursue the client's areas of personal interest and enthusiasm.

The hours between 20:30 and 08:30 in the morning are dedicated rest hours. Fatigue management plays a strong role in maintaining a client's engagement in the rehabilitation programme and this time of rest is important to give the best opportunity for good progress the next day.

SETTING OF SERVICE

Auckland

The ABI Rehabilitation intensive programmes are provided in a purpose-built 33-bed rehabilitation campus. While on-site, clients live in one of five home-like houses. Each house has between 2-8 bedrooms. They have their own 'character' suitable to the needs of the client. This includes a low-stimulation environment for clients with low-level consciousness, and a safe treatment environment suitable for clients with significant behavioural issues. The majority of houses are fully wheelchair-accessible and have to-the-door access for ambulances and transport vans. Additionally, the campus has community facilities, areas for outdoor recreation, and ample green space including a sculpture garden; all are intended to return to social participation and integration. Larger central buildings contain the administration offices and rehabilitation facilities including a gym, family cafeteria, treatment and training rooms.

Wellington

The Wellington intensive rehabilitation programme is located on the grounds of the former Porirua Hospital campus in Porirua. It is a large building with a mix of two four bedded rooms, 6 single bedrooms and 5 single transitional bedrooms (preparing for discharge). The programme has the capacity for 18 intensive rehabilitation clients. They can also accommodate slow stream / longer-term rehabilitation clients on the main site (10 single rooms). There is a communal lounge with a large T.V and music/entertainment system and dining room which is set in a 'café' style. The site has a secure outdoor garden courtyard which is used by clients and families for socializing, barbeques, and activities. The indoor and outdoor areas are wheelchair accessible. There are two family/whānau rooms and a prayer room which is available for quiet client/family times. There are laundry facilities on site, so that clients can take part in domestic activities, as soon as they are able. The site also includes a number of clinical spaces including a physio gym and activities room. The facility is located close to the Porirua shopping complex and accessible by both train and bus services.

SERVICE FUNDING

All clients entering the service must have an established funder prior to starting a programme. The funder may be ACC, MoH, DHB, Private insurance or Self-funding.

ACC Funding

ABI Rehabilitation holds the Traumatic Brain Injury Residential Rehabilitation (TBIRR) contract allowing for admission into the following services

- Emerging Consciousness Service (ECS)
- Residential Rehabilitation (RR)
- Day Rehabilitation (DR)

This TBIRR contract is for clients aged 16 years and over who have sustained a moderate to severe TBI. There are maximum stay limits for each programme. The maximum stay limit is 90 days under the ECS contract and 180 days for the RR contract.

Typically, clients are referred following an initial period in hospital following a TBI, however community based clients may also enter this contract with ACC case manager approval.

MOH and DHB Funding

ABI Rehabilitation holds a MoH contract and will facilitate individual contracts as required for DHB's. Following a referral, ABI will complete a pre-admission assessment and determine appropriateness of referral. Clients are aged between 16 and 65 and are typically TBI (not covered by ACC), stroke or other neurological condition.

The ACC, MoH and DHB contracts will fully cover the rehabilitation costs during the stay. For costing on privately funded (private insurance or self funding) please contact ABI Rehabilitation service managers to discuss.

General

ABI Rehabilitation has admission and exclusion criteria for clients entering our programs. These criteria are centred on contractual eligibility, medical stability and the client's ability to benefit from rehabilitation. The criteria are available to staff to assist with the pre admission screening process. ABI-NZ works within contractual geographic boundaries, though we can accept clients from outside these areas on occasion if it is requested by our funders.

Discharge

Discharge planning commences from the day of admission to an intensive rehabilitation programme. Average length of stay in intensive inpatient rehabilitation is approximately 35 days however this is very dependent on the seriousness of the injury and social supports available. Around 90% of clients return home after intensive rehabilitation.

The discharge process involves input from the client, their whānau, funders and the rehabilitation team. The process will vary between clients – dependent on their needs and situation. All clients will have a keyworker (key person who acts as a link between the rehabilitation team, funder and family / client) who will coordinate the discharge process. There is typically a discharge planning meeting before discharge occurs (although often the process towards discharge is already underway). There may be a home assessment prior to discharge to assess the environmental needs before discharge. Recommendations are made by the interdisciplinary team to the funder to the support discharge and rehabilitation needs required post-discharge.

When indicated, ABI Rehabilitation is able to provide support for the ACC clients post discharge (2 hours / month for 6 months). This may be to support or educate the carers within the discharged facility on brain injury matters or assist with individualised care or rehabilitation plans.

Discharge Criteria

Discharge criteria vary depending on the client's and whānau presentation and needs. However, at the time of discharge the team has assessed the clients continuing rehabilitation needs and have confirmed this no longer needs to be provided within a specialized intensive rehabilitation setting. Discharge may be to the client's previous home, family members home, community slow stream / long term rehabilitation setting or occasionally to a higher level of nursing care (such as a rest home or private hospital). Over 90% of clients entering the intensive rehabilitation service are discharge home.

Transition Home

Clients returning home will frequently have a progressive discharge plan than may involve a day trip home, followed by overnight leave through to weekend leave. This is to trial the situation and determines if any issues may arise on discharge so they can be addressed early. Any clients having home leave will be sent home with an information sheet that is relevant to them; the sheet outlines rehabilitation activities and potential risks. Included on the form is a section for client and whānau feedback as to how they perceived the stay to go.

Transition to other Facilities

There are times when a client no longer requires intensive rehabilitation for their brain injury but is not yet ready to return home (due to multiple orthopaedic injuries, for instance) or the option of home may not be available to them. In discussion with the client, whānau and funder a referral may be sent (from the funder) to one of the residential (slow stream / long-term) rehabilitation services in their local area. Families are encouraged to visit the other services and when it is a local service we will arrange for a client visit. Recommendations via our discharge report along with a handover to the next provider are given.

SLOW STREAM REHABILITATION (RESIDENTIAL) PROGRAMME

Person Centred Plans (PCP)

The slow stream rehabilitation programme in Auckland and Wellington offer comprehensive 24-hour care for clients. The goal for this service is to assist the clients in attaining the best quality of life through client-centred activity programmes including slow-stream rehabilitation and recreation within a community setting. Each year the client, family, case worker and staff meet to review the client's plan and update or set new goals. The staff then develop a plan with the client (PCP) to achieve the goals.

Rehabilitation goals, as appropriate, form part of the PCP. These goals in addition to having a community participation purpose will also focus on improving functional ability e.g. improving communication, mobility, or behaviour within community settings. The plans and support may also involve life skills such as community sporting activities and volunteer / supported employment work.

Outings to the community are encouraged including; trips to the library, the community centre, church, parks, the gymnasium, the swimming pool, beaches, the DVD shop, the dairy, the shopping mall, and cafes. One-off activities also include trips to the zoo, the city, the waterfront, rugby games, the Butterfly Farm, the Honey Centre, museums, etc.

Client visits to their family home are facilitated and family are encouraged to visit and participate in the activities. When appropriate, there is association between the clients living areas and they may visit each other for social morning teas, BBQs, and to play pool, basketball, bingo and other games. Client care is supported by:

- Registered nursing working within the service 24/7
- Client Support Workers providing 24-hour care and client-focused activities within the community
- Occupational therapy and physiotherapy, along with
- Consultations with the rehabilitation physician, the neuropsychiatrist, neuropsychologist, speech-language therapist, and dietician as indicated by the client's rehabilitation plan.

Setting of Service

In Auckland there are 7 houses with a total of 40 beds. One house is located on the on-site campus. All houses are located within the local communities of Ranui, Swanson, Te Atatu and Kumeu. The houses have a “family home away from home atmosphere”. Each client has his/her own room and is encouraged to personalise it. All houses have a lounge, dining area and kitchen. All meals are prepared by staff in the individual house kitchens. Clients’ dietary and cultural food requirements are met.

The clients are allocated to a house according to their medical and rehabilitation needs. The houses have been modified and equipped as appropriate. There are wheelchair-accessible houses, and a safe house for the cognitively impaired.

In Wellington there are two locations. One is the main campus in Porirua which can accommodate up to 10 clients. The other is a 4 bedroom house in Whitby.

Clients living at the main campus are those requiring a higher level of nursing and medical input. The service has RN oversight 24 hours per day and is staffed by Enrolled Nurses and Rehabilitation Programme Workers. Depending on their condition, clients have weekly outings into the community.

The community house in Whitby is for the more independent clients who require less medical and nursing oversight but are unable to live independently.

Access to Service

The Programme is available to clients over 16 years of age who have an acquired brain injury. Referrals are typically from ACC or Ministry of Health for clients with TBI, stroke or other neurological impairment that cannot live independently. The service accepts and cares for clients who are in a persistent vegetative or minimally conscious state requiring full assistance with all activities of daily living through to those who with support / education may be discharge back to the community.

Discharge from service

Discharge/transition from long term residential services to another level of care, or back to the community, is supported and encouraged where appropriate. ACC case managers and/or the Needs Assessment and Service Coordination (NASC) service are involved in the discharge process, as are the rehabilitation team, client, family, and the client’s GP.

COMMUNITY SERVICES

Services/programmes

Current services include;

- Concussion for children and adults
- Vocational rehabilitation and assessment
- Neuropsychological assessment for children and adults
- Psychological services for children and adults
- Training for Independence for children and adults
- One-off assessments from any of the disciplines
- Spasticity assessments and treatments.

The services are provided by a range of professionals. The Multidisciplinary team includes:

- Occupational Health Physician
- Rehabilitation Physician
- Physiotherapy
- Neuro and Clinical Psychology
- Speech Language Therapy
- Occupational Therapy
- Dietetics
- Social Work
- Rehabilitation Coach.

Clients are provided with information about the service, and information about their health condition and other external agencies that may be able to offer advice and support. The client's care is planned from an assessment of their rehabilitation needs. Often a client will need to receive services from more than one of the ABI team. The multidisciplinary team work to provide coordinated care. This ensures each client receives a seamless specialist service with great outcomes.

Setting of service

The Auckland community services are provided from a professional suite of offices in Grafton. The building is accessible for all people, is close to public transport and has plenty of free parking. We always endeavour to warmly welcome all visitors and clients. The Wellington community service is based in Tawa, near the main site in ABI Wellington. This service is in an accessible building and is also close to public transport (buses and train).

The multi-disciplinary team visit most of their clients in the community as the focus of the community service is to support our clients with return to independence in their homes, work places and communities.

Access to Service

Clients are accepted to our services either on receipt of an appropriate referral from ACC, or from self or GP referral. We work with clients of any age with any injury.

Community services in Auckland are largely funded by and referred through ACC. There are however options for individuals to fund their own community rehabilitation, or for other services to fund community and outpatient services. The clients that are seen by the community rehabilitation team have a wide range of injuries from mild to moderate traumatic brain injury through to fractures and sprains.

Discharge from Service

Clients are discharged from our services once they have reached a pre-determined level of independence with either work, home and/or community activities. There are some ACC funded services that are a “one off” assessment and so the client may be discharged after one episode of intervention (i.e. independent occupational assessments, neuropsychological screens, etc.).