Hypoxic brain injury post-intensive rehabilitation: Are clients and families ready for discharge?

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Introduction

A gap in service delivery was identified in transitioning and discharge planning clients following inpatient rehabilitation for hypoxic brain injury (HBI) in New Zealand. Anecdotally, inequalities have been reported in community based services, to the detriment of clients' long-term outcomes. Further data is required to improve seamless service delivery.

Methods

ABI rehabilitation therapists completed structured phone interviews gathering qualitative feedback from client/family members to review "how they are coping after leaving ABI". This information was analysed with the aim of improving services for future clients with HBI.

Results

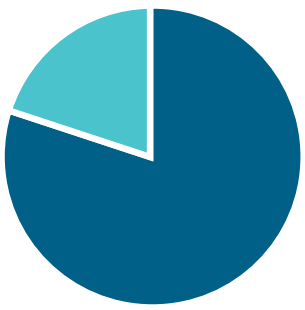
5

5 family/clients provided experiential feedback:

Families felt unprepared.

Families reported they had inadequate supports set up prior to discharge.

Families sought multiple resources outside of the standard community therapy to fill the gap.



Discharge location

- Home
- Residential facility

Life after discharge

- Found life easier
- Found life as expected
- Found life harder than expected

Positive family and friend support

Maintaining friendships from rehab post discharge

Family unit moved into together

Social changes in the family system

Changing roles – mother to caregiver

Lack of government funding

Utilising external agencies e.g. NZ Disabilities, Blind Foundation, Optionz

Social participation

Catching trains and buses

Going to the movies and ten pin bowling

Walking for exercise

"Shake Rattle and Roll"

Discussion

Families reported that overall therapy supports following discharge were inadequate or non-existent and felt under prepared for family members' return home. Education and information provided whilst at ABI Rehabilitation was excellent, they still felt overwhelmed and underprepared when discharge occurred. Results found that seamless service delivery was poor and varied depending on location, funding source, and service availability. An unexpected finding was the need for therapists to provided additional support and arrange referrals to meet identified gaps. To address these issues, ABI Rehabilitation has initiated discharge planning from admission.

This project was completed by the allied health team members as a quality improvement project at ABI Rehabilitation intensive service, Auckland.

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