ABI Rehabilitation Scope of Service 2019

abi Rehabilitation

Overview

He honore, He kororia ki te Atua, He maungarongo ki te whenua, He whakaaro pai ki ngā tangata katoa. Tihei mauri ora.

Honour and glory to the Almighty, peace on earth and wellbeing to all mankind. Sneeze of life.

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 acquired brain injury (ABI). With facilities in Auckland and Wellington ABI Rehabilitation provides services to people throughout New Zealand and internationally as required. The services available are outlined within this document and include:

Intensive inpatient rehabilitation

Day rehabilitation

Residential rehabilitation

Community services

Intensive Inpatient Rehabilitation – Auckland and Wellington

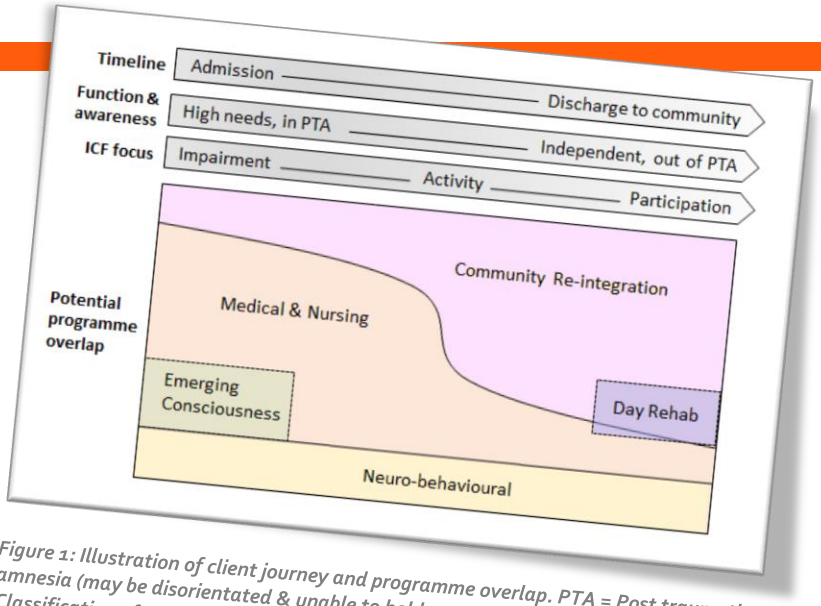

Figure 1: Illustration of client journey and programme overlap. PTA = Post traumatic amnesia (may be disorientated & unable to hold onto new memory), ICF = International Classification of Function

ABI Rehabilitation offers comprehensive inpatient services for people aged 16 years and over, however with family and funder approval exceptions may be made for younger people that are more suited to an adult service). Our goal, through the rehabilitation process is to assist the client in attaining the highest functional level possible and to enhance their quality of life.

A comprehensive assessment and individualised client centred rehabilitation plan is developed preferably with input from their family-whānau. This plan is reviewed and modified as determined by client's needs.

PROGRAMMES

The intensive inpatient rehabilitation programme is based on the needs of the client.

ABI have numerous rehabilitation programmes that the client progresses through during their rehabilitation (see figure 1). They do not sit necessarily within one programme, but rather take the appropriate components from the relevant programme.

Programmes include:

The Emerging Consciousness Programme is a programme for those presenting in a minimally conscious state. This programme is focused on medical and nursing management preventing complications, sensory stimulation, early cognitive interventions and family-whānau education and support.

The Medical and Nursing Rehabilitation Programme focuses on early intervention to maximise wellbeing and minimise medical complications. The interdisciplinary team addresses potential impairments such as swallowing issues, tracheostomy management, skin integrity and medication management.

The Neuro-behavioural Rehabilitation Programme, led by the psychology team, is intensively managed by staff with skills in behaviour management and cognitive rehabilitation.

The Community Re-Integration Programme provides individualised transitional rehabilitation with a strong focus on involving clients in the community in preparation for returning home, and providing education and support to families-whānau.

For clients able to reside at home and live local to the facility, the Day Rehabilitation Programme may be a more suitable option. Due to contractual restrictions, this is only available for ACC 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.

CONTACT DETAILS

To request programme brochures please send an email to enquiry@abi-rehab.co.nz or visit our website www.abi-rehab.co.nz and send us an enquiry via the contact form.

Staffing: The team consists of the following disciplines who work together to deliver an interdisciplinary approach to rehabilitation:

Rehabilitation nursing – on-site 24 hours per day
Rehabilitation assistant – on-site 24 hours per day
Rehabilitation programme coordinator/facilitator – on-site Monday through Sunday
Rehabilitation medicine – on-site during working week and on-call arrangements after hours
Specialist key work, Physiotherapy, Occupational therapy, Speech language therapy, Neuro/clinical/behavioural psychology, Social work – on-site Monday through Friday
Kaiarahi Kaupapa Māori (Māori cultural support)
Neuro psychiatry – clinics or referral
External specialties (e.g. podiatry, dietician) are available on an as-required referral basis.
Other rehabilitation services such as massage therapy, and pet therapy are also available.*

**Auckland*

REHABILITATION PROGRAMME STRUCTURE

The inpatient rehabilitation programme is structured around a normal "working" day to ensure a balanced approach to life while the client is residing at ABI.

The **'intensive therapy 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.

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.

REHAB PROGRAMME STRUCTURE

8:30-15:30: "work hours"

15:30-20:30: "recreation and social"

20:30-8:30: "rest hours"

Cultural: Nau mai, piki mai, whakatau mai.

Korowai

Whakaritenga Mahi (Māori Services Model) is a practical guide to providing culturally appropriate rehabilitation services. It places the client and their whānau at the centre of rehabilitation planning, implementation and evaluation. Building an environment, to use the metaphor of the korowai (feathered cloak), to ensure that all those who come through the threshold of an ABI centre into an environment of manaakitanga, safety, warmth and security that a korowai provides when worn.

SETTING OF SERVICE

In **Auckland** the ABI Rehabilitation intensive programmes are provided in a purpose-built 33-bed rehabilitation campus. While on-site, clients live in one of six home-like houses. Each house has between 2-8 bedrooms. The houses have their own 'character' suitable to the needs of the client.

House at the Auckland rehab campus

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 communal areas for outdoor recreation, and ample green space including a sculpture garden; all are intended to assist social participation and integration. Larger central buildings contain the administration offices and rehabilitation facilities including a gym, family cafeteria, and treatment and training rooms. The local train is an easy 5-minute walk away with buses located close by also.

NUMBER OF BEDS

Auckland: 33 beds across 6 houses

Wellington: 18 beds within 1 facility

The Wellington intensive inpatient rehabilitation programme is soon to be re-located to a new 24-bed purpose-built rehabilitation unit on Hospital road, Porirua. Currently it is located at Kelvin House on the grounds of Manor Park. It is a large building with 18 single bedrooms dedicated to the intensive inpatient programme.

The location of the bedrooms, around a central nursing station, allows for grouping clients with similar needs, interests or age.

There is a communal lounge and dining room. The site has a secure outdoor garden courtyard which is used by clients and families for socialising, barbeques, and activities. The indoor and outdoor areas are wheelchair accessible. There are laundry facilities and a client kitchen on site, allowing clients to take part in domestic activities, as soon as they are able. The site also has a number of clinical spaces including a physio gym and activities room. The facility is located close to Queens Gate shopping complex and accessible by train services.

Wellington Main Site

FUNDING AND REFERRALS

Client accommodation, food, laundry, care and rehabilitation fully funded. Personal items e.g. toiletries, medications not covered by your claim, additional services you may seek or require e.g. dentistry costs are not covered. Please discuss with your case manager or key worker.

Typically, there is one assigned funder. However, in some circumstances co-payments between a range of funders may occur.

CONTACT DETAILS

Auckland: +64 9 831 0070

Wellington: +64 4 237 0128

The majority of clients receiving services within the intensive service present with traumatic brain injury (TBI). Clients with secondary complications including, but not limited to, spinal cord damage, multi-trauma, limb loss, orthopaedic injuries will also receive appropriate rehabilitation. Rehabilitation is also offered for stroke rehabilitation and other neurological presentations that may benefit from intensive rehabilitation.

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

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

This TBIRR contract is for clients aged 16 years and over who have sustained a moderate to severe traumatic brain injury. There are maximum stay limits for each programme. The maximum stay limit is 90 days under the EC contract and 180 days for the RR contract. The DR contact allows for residential nights if required.

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 contracts with MoH and some DHBs.

Individualised contracts can be established as required. Following a referral, ABI Rehabilitation 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.

Private Funding: For costing on privately funded services (private insurance or self- funding) please contact ABI Rehabilitation service managers to discuss.

FUNDERS

Accident Compensation Corporation (ACC)

Ministry of Health (MoH)

District Health Board (DHB)

Private Funders

TRANSITIONS

Admission: ABI Rehabilitation has admission and exclusion criteria for clients entering our services. 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. TBIRR has contractual geographic boundaries (North Island and Nelson/Marlborough), though we can accept clients from outside these areas if requested by our funders.

Clients with an accepted ACC claim for a moderate to severe TBI can access the services directly from the hospital (DHB) or from the community. If entering via the community or into the Emerging Consciousness programme, case manager approval is required. Non-ACC referrals require prior funding approval. Admissions may be for sub-acute intensive rehabilitation, day rehabilitation or a burst of rehabilitation.

ABI Rehabilitation has a team of brain injury nurse specialists (BINS) who work within the DHB's and assist the hospital staff in the assessment and referral process. Their role is to also work with the families-whānau and clients to provide education surrounding brain injury and their potential pathway. They will also work closely with the ABI facility team to provide up to date information surrounding the health and rehab status of the client and their needs ensuring a seamless transfer into the inpatient rehabilitation unit. Clients entering under the ACC TBIRR intensive inpatient contract have prior approval for funding providing they meet the contract requirements.

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.

The discharge process involves input from the client, their family-whānau, funders and the rehabilitation team and where necessary the accepting community provider(s). 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-whānau/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 and make equipment recommendations as appropriate. The interdisciplinary team also makes recommendations to the funder to 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 rehabilitation plans.

Discharge Criteria vary depending on the client's and family-whānau presentation and needs. However, at the time of discharge the team has assessed the client's continuing rehabilitation needs and have confirmed these no longer need to be provided within a specialised intensive rehabilitation setting. Discharge may be to the client's previous home, family member's home, residential 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 discharged home.

Transition Home: Clients returning home will frequently have a progressive discharge plan that may involve a day trip home, followed by overnight leave through to weekend leave. This is to trial the situation and determine 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 is a section for client and family-whānau to provide feedback following the leave period. Within the discharge planning, recommendations and handovers are given to the community based rehabilitation provider to enable continued rehabilitation in the community. This process is streamlined with pre approval and the ability to engage with the community providers pre discharge.

Transition to other Facilities: There are times when a client no longer requires intensive rehabilitation for their brain injury but is not yet able or ready to return home or the option of home may not be available to them. In discussion with the client, family-whānau and funder a referral may be sent (from the funder) to one of the residential 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.

Residential Rehabilitation – Auckland and Wellington

The residential rehabilitation services in Auckland and Wellington offer comprehensive 24-hour inpatient 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-whānau, funder and staff meet to review the client's plan and update or set new goals. The staff members then develop a plan with the client to achieve the goals.

Rehabilitation goals, as appropriate, form part of the plan. 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, community centre, sailability, church, parks, gym, swimming pool, movies, beaches, the DVD shop, the dairy, the shopping mall, cafés and local university for appropriate applied courses. One-off activities also include trips to the zoo, the city, the waterfront, rugby games, the Butterfly Farm, the Honey Centre, mini golf, adventure park, museums, etc.

Client visits to their family home are facilitated and family-whānau are encouraged to visit and participate in ABI based activities. When appropriate, there is association between the clients houses 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 nurses working within the service 24/7
Rehab assistants providing 24-hour care and client-focused activities within the community
Rehabilitation programme coordinators/facilitators – on-site Monday through Friday
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 presentation and rehabilitation plan.

SETTING OF SERVICE

In Auckland there are 7 houses with a total of 46 beds. All houses are located within the local communities of Ranui, Henderson heights, Swanson, Te Atatu and Kumeu. The houses have a "family 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 with client having input into meal planning and preparation where possible.

Glenburn House in Kumeu

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.

NUMBER OF BEDS

Auckland: 46 beds across 7 houses in West Auckland

Wellington: 10 beds (6 at main site + 4-bedroom house in Whitby)

In Wellington there are two locations. One is the main campus at Manor Park which can accommodate up to 6 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 an Enrolled Nurse and Rehabilitation Assistants (RAs).

Wellington Main Site

The community house in Whitby is for the more independent clients who require less medical and nursing oversight but still receive supervision/support throughout the day from RAs.

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 upper age limit for MoH clients is 65 years.

On receipt of a referral from the funder, a pre-admission assessment is conducted. In consultation with the client/family, funder and ABI if appropriate, admission details are planned.

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 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-whānau, and the client's GP.

RESPITE CARE OPTIONS

At times, clients with acquired brain injury who are residing in a private residence may benefit from a period of respite care. Such arrangements, providing there is a room within a suitable location, can be made. Prior funding approval is required.

Community Services

SERVICES/PROGRAMMES
Provision of specialist services for both adults and children. Services include both assessments and treatment programmes.

The clients that are seen by the community rehabilitation team have a wide range of injuries from mild to severe traumatic and hypoxic brain injury through to fractures.

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

Occupational Health Physician
Rehabilitation Physician
Physiotherapist
Neuro and Clinical Psychologist
Speech Language Therapist
Occupational Therapist
Registered Nurse
Social Worker
Dietitian
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. With treatment based services, the client's rehab is planned following an assessment of their rehabilitation needs. Often a client will need to receive services from more than one of the ABI team members. The interdisciplinary team work under the guidance of a keyworker to provide coordinated care. This ensures each client receives a seamless specialist service with great outcomes.

SERVICE FUNDING
The majority of the contracts held are fully funded under ACC however there are other non-ACC services available.

ACC

Some of these services are regional others are national.

National:

- Support Needs Assessments
- Education Based Rehabilitation Assessments
- Retrospective Personal Support Assessment
- Spasticity Management Services

Auckland, Northland and Wellington based:

- Concussion Services

Auckland and Wellington based:

- Training for Independence Services
- Medical Specialist Assessments
- Neuropsychological Assessments
- Psychological Services
- Vocational Services
- Social Rehabilitation Needs Assessments

Auckland based:

- Initial Occupational Assessment
- Initial Medical Assessment
- Vocational Independence Medical Assessment
- Specialised Wheelchair and Seating Assessments

Non-ACC

Restores – this is a pilot project to provide provisional services funded by Auckland and Waitemata DHB's to support clients with a mild to moderate stroke back to work.

Private – There is the ability for those wishing to access the services via private funding.

Other Agency Private – ABI is able to provide a range of therapy services to other agencies requiring support. We currently support clients via Oranga Tamariki, MOE Intensive Wraparound Services (IWS) and MOH.

SETTING OF SERVICE
The Auckland community services are provided from a professional suite of offices in both Grafton, Botany and Northwest shopping centre.


Grafton Office

The buildings are accessible for all people, close to public transport and have plenty of free parking.

The Wellington community service is based in Tawa. This service is in an accessible building and is also close to public transport (buses and train).

Tawa Office

The inter-disciplinary team visits 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. Outpatient clinics are also held at the main facilities. These are managed via a booking/ appointments system. Support people are welcome to attend these with the client.

CONTACT DETAILS

To make a referral please send an email to:

community.referrals@abi-rehab.co.nz

To get assistance with a referral please email:

enquiry@abi-rehab.co.nz

ACCESS TO SERVICE

Referrals can come via ACC, GP's or self-referral. However, prior to an assessment funding approval is required.

DISCHARGE FROM SERVICE

Clients are discharged from our community 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.).

Northwest Office