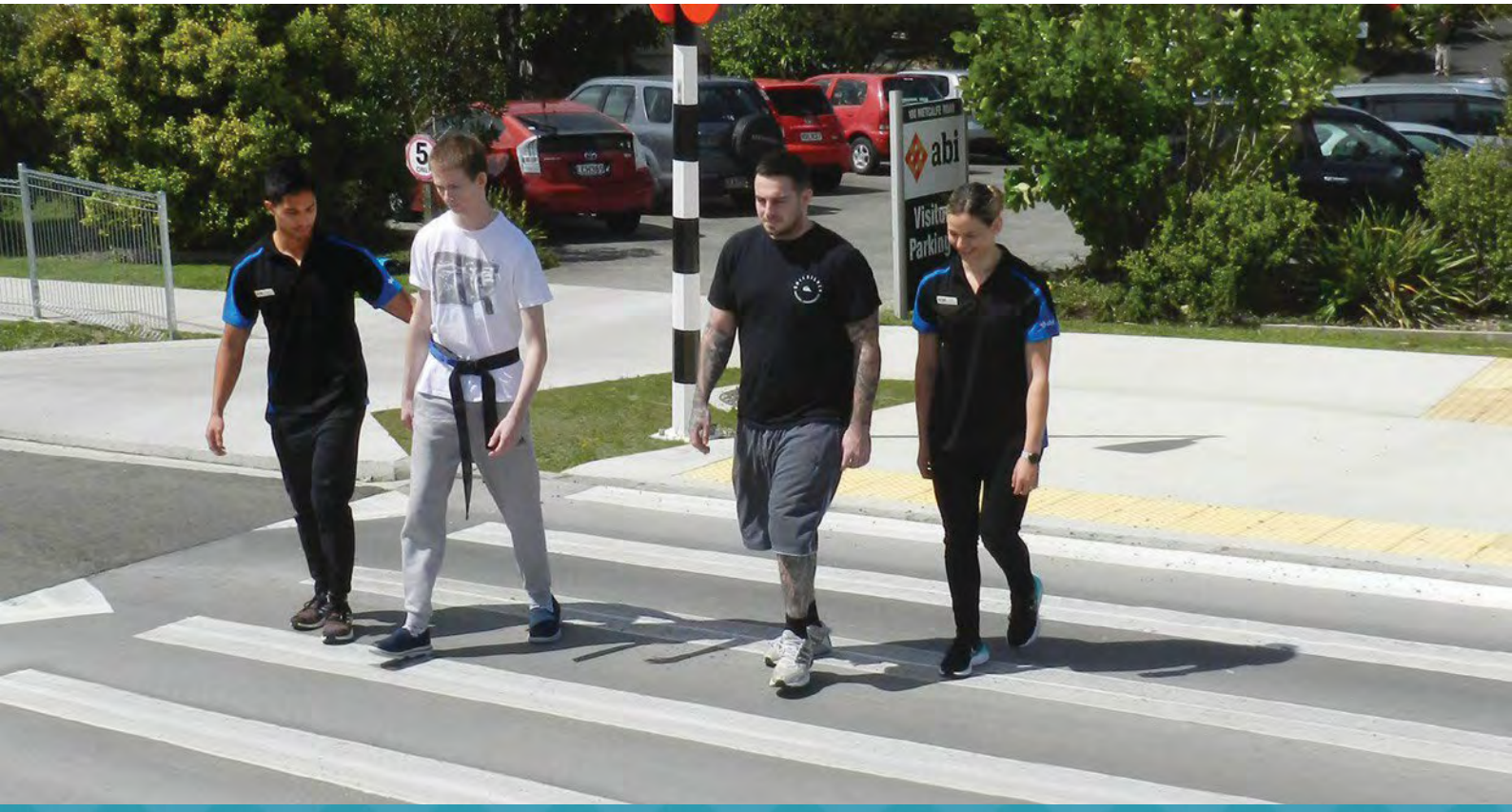

Scope of Service

ABI Rehabilitation is a leading New Zealand provider of comprehensive, specialised rehabilitation services for people with an acquired brain injury (ABI) following a head injury or stroke.

Kia mau ki te tūmanako,
Te whakapono me te aroha

Hold fast to hope,
faith and love

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Te Hekenga-ā-Ora Māori Development Plan 2022-2025

The role of whānau (families) is deemed an essential aspect of hauora (wellbeing) by Māori, who are overrepresented in populations where there is injury to the brain. Family/whānau knowledge systems can greatly improve recovery outcomes for those with such injuries.

Te Hekenga-ā-ora (The journey to wellbeing) sets out a framework to improve ABI's cultural responsiveness and ensure services are culturally safe to improve Māori experience of rehabilitation. This is the first national Māori Development Plan for ABI, built on a foundation of Te Tiriti ō Waitangi partnerships.

Te Hekenga-ā-Ora symbolizes the journey a client and whanau embark on following an injury to the brain yet also acknowledges that the journey is different for everyone. ABI holds the client and whānau at the centre of its waka hourua (double hulled waka), with one hull representing western science and skills and the other hull representing mātauranga Māori (traditional Māori knowledge).

ABI recognises that in order to achieve good outcomes for Māori, staff must braid the two knowledge systems together and apply that to all services when working with Māori clients and whānau.

Te Hekenga-ā-ora outlines four pōkarekare (strategic ripples) along with short, medium and long term actions.

Overview

Choosing the right rehabilitation provider is important. Formed in 1996, ABI Rehabilitation partners with clients and their families/whānau to help achieve the best possible outcomes.

Everyone has the right to access quality rehabilitation services. In line with our vision, we aim to deliver world-class client experiences and outcomes through our rehabilitation services for anyone with a traumatic brain injury (TBI) or a non-traumatic brain injury (NTBI) such as a stroke.

Our inpatient and residential facilities, located in Auckland and Wellington, are available to people across New Zealand. We also have a network of regional clinics throughout the North Island.

Our Community services provide neuro-rehabilitation to adults and children in the greater Auckland, Northland and Wellington regions, and assessment services across New Zealand. We serve people with a diverse range of impairments, such as TBI, concussion, complex medical, orthopaedic, or spinal cord conditions. We have six clinic branches – three in Auckland, and one each in Whangārei, Wairarapa & Wellington.

Our services:

Intensive inpatient rehabilitation and day rehabilitation

Residential rehabilitation & support services

Community services: clinical rehabilitation, specialist assessments & equipment provision

Paediatric assessment and rehabilitation

Why choose ABI Rehabilitation?

EXPERIENCE COUNTS

ABI Rehabilitation is New Zealand's longest-serving provider of specialist brain injury rehabilitation services.

Our compassionate and trustworthy staff are experts in the specialised field of neuro-rehabilitation. They develop customised rehabilitation programmes to match the needs of each individual and their family/whānau.

CONTINUUM OF CARE

ABI Rehabilitation offers a comprehensive range of services across the continuum of care. These include assessments, medical treatment, rehabilitation, rehabilitation equipment, post-acute community care, and lifelong support programmes.

"Thank you ABI for your kete of knowledge regarding brain injuries, the support that was given to me to bring me home, and the continued support for us once we have left ABI. Thank you for the awesome staff support."

Rehabilitation programmes include:

- Disorders of consciousness
- Medical – nursing rehabilitation
- Community reintegration
- Neurobehavioural
- Pastoral care
- Family education
- Assistive technology
- Concussion rehabilitation
- Return to work Vocational programmes
- Medical assessments
- Community rehabilitation
- Recreation therapy and adaptive rehab programmes – including hydrotherapy, art, music, horticulture and outdoor experiences
- Peer support
- Pain management
- Health and wellness
- Behaviour support programmes
- Paediatric assessment & rehabilitation
- Pet therapy
- Transition support for return to home
- Specialised wheelchair seating and positioning
- Upper extremity rehabilitation
- Spasticity management
- Vestibular and balance
- Needs assessments

ACCREDITATION

ABI Rehabilitation is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The body assesses healthcare service providers across the world against a set of standards specific to the types of service they deliver. Accreditation demonstrates a commitment to achieving high standards of care.

In 2012, ABI Rehabilitation became the first Australasian rehabilitation organisation to receive CARF accreditation. With its commitment to continuous quality improvement, it has succeeded in maintaining its accreditation.

ABI Rehabilitation also holds certification against all New Zealand quality standards relevant to rehabilitation services.

CLIENT AND FAMILY/WHĀNAU EDUCATION

Clients and family/whānau can attend training sessions to learn more about their injury or illness. This enables them to actively participate in the rehabilitation process and develop a strong understanding of ongoing medical care and rehabilitation.

OUTCOMES AND SATISFACTION

ABI Rehabilitation treats hundreds of people with brain injuries every year and is proud of the outcomes achieved by its clients. Client outcomes and satisfaction information can be found on 'scorecards' on the ABI Rehabilitation website, along with information on gender, age, ethnicity and mechanism of injury.

http://www.abi-rehab.co.nz/outcomes/

PARTNERS IN RESEARCH

ABI Rehabilitation contributes to research that

continues to improve neuro-rehabilitation. Research is often in collaboration with New Zealand universities. Exciting areas of research include different models of care and the use of new technologies and equipment that assist in rehabilitation.

CLIENTS SERVED IN 2021 BY ABI

Intensive

338

Residential

47

Community

Concussion	Community Rehab (TI)	Assessments
1054	**874**	**953**

Intensive Inpatient Rehabilitation

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 if they are more suited to an adult service. It is our goal to enable clients to achieve the highest level of function and quality of life possible.

Most people are referred to the inpatient intensive rehabilitation service by a public hospital. However, ABI Rehabilitation also accepts referrals for anyone living in the community who needs inpatient or day rehabilitation.

The phases of transition to and from the ABI Rehabilitation service are key moments. Our aim is to make these as seamless as possible through effective handover and planning.

PROGRAMMES

Through intensive inpatient rehabilitation, we help clients gain as much independence as possible as they look to rebuild their lives. Clients and family/whānau may be put on one or parts of several rehabilitation programmes depending on their particular needs.

Programmes include:

The **Emerging Consciousness Programme** is for people in a minimally conscious state, who are often not ready to begin an active rehabilitation programme upon entry to the service. It focuses on medical and nursing care to prevent complications, sensory stimulation, early cognitive therapy and family/whānau education and support. Close monitoring and assessment enables ABI Rehabilitation to alter a client's programme to aid their recovery.

The **Medical and Nursing Rehabilitation Programme** focuses on early interventions to improve wellbeing and minimise medical complications. It includes areas such as swallowing issues, tracheostomy management, skin integrity and medication management.

The aim of the **Neurobehavioural Rehabilitation Programme** is to give clients the tools they need to take control of their own behaviours.

The **Community Re-Integration Programme** prepares clients to return home and participate in the community. It also includes providing education and support to family/whānau.

If clients are able to reside at home and live locally, the **Day Rehabilitation Programme** may be an available option. Access to therapy is similar to inpatient services.

The **Stroke Rehabilitation Programme** helps those who have experienced a stroke to relearn skills. It also includes education and training for family/whānau. — for example, so that they can identify risks that lead to complications including another stroke.

The rehabilitation team is guided by a rehabilitation physician, who develops individual treatment plans based on each client's recovery goals. Staff understand that after an acquired brain injury, people often struggle to navigate a new way of life. Our services are designed to meet the physical, cognitive, medical and emotional needs of each person as they work towards independently accomplishing activities such as working, driving and parenting.

STAFFING

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

Rehabilitation Nursing
On-site 24 hours per day

Rehabilitation Assistant
On-site 24 hours per day

Rehabilitation Medicine
On-site during working week and on-call arrangements after hours

Specialist Coordination
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)
Available on an as-required referral basis

Other Rehabilitation Services
Such as massage therapy and pet therapy are also available

REHABILITATION PROGRAMME STRUCTURE

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

The **'intensive therapy work hours' between 08:30 and 15:30** are dedicated to intensive rehabilitation around a structured timetable of medical, therapy, nursing and self-directed rehabilitation activities. These are built around the goals, strategies and steps that have been agreed with each client and their 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 social and family relationships are maintained and that there are opportunities to pursue areas of personal interest.

The hours between **20:30 and 08:30 are dedicated rest hours**. Fatigue management plays an important role in maintaining engagement in the rehabilitation programme. A time of rest gives each client the best opportunity for progress.

CULTURAL NEEDS

Nau mai, piki mai, whakatau mai.

Clients and their whānau are at the centre of rehabilitation planning, implementation and evaluation. Te Hekenga-ā-ora (Māori Development Plan) guides and supports staff in providing culturally appropriate rehabilitation services.

We ensure that everyone entering an ABI Rehabilitation centre experiences manaakitanga, safety, warmth and security – feelings that are experienced when a korowai (feathered cloak), is worn.

SETTING OF SERVICE

In **Auckland**, the ABI Rehabilitation intensive programmes are provided in a 33-bed rehabilitation campus. While on-site, clients live in one of seven comfortable houses. Each house has 1-8 bedrooms and has its own 'character' suitable for the needs of those residing in them. This includes a low stimulation environment for clients with a low level of consciousness and a safe treatment environment for those with significant behavioural symptoms. With the exception of the 1 bedroom units, the 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. Larger central buildings contain the administration offices and rehabilitation facilities, including a gym, family cafeteria and treatment and training rooms.

The Ranui train station is an easy 5-minute walk away and bus stops are also located nearby.

AUCKLAND

7 houses

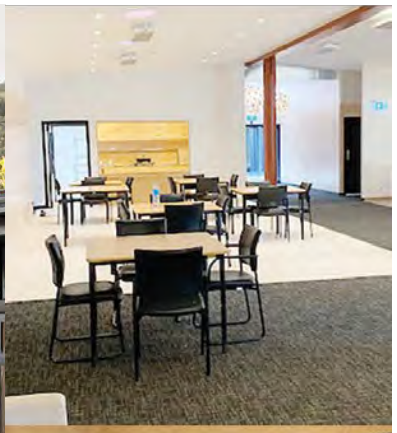
33 beds

The **Wellington** intensive inpatient rehabilitation programme is provided at a new 25-bed rehabilitation centre in Porirua.

The indoor and outdoor areas are wheelchair accessible, and rooms are located around a central courtyard. There is a communal lounge and dining room as well as areas for clients and family/whānau to socialise and engage in hobbies. With on-site laundry and kitchen facilities, clients can perform day-to-day domestic activities as soon as they feel able to. The centre also features a number of clinical spaces, including a physiotherapy gym and activities room. In addition there is separate self-contained unit located onsite.

WELLINGTON

1 Centre
25 beds



SECONDARY COMPLICATIONS

ABI Rehabilitation understands that people requiring intensive brain injury rehabilitation often present with one or more significant secondary complications (comorbidities) such as spinal cord injury, limb loss, multiple fractures, internal injuries or cardiovascular complications.

As part of the pre-admission process, the rehabilitation medical specialist and nurse specialist determine medical stability and work with all those involved to make recommendations ahead of entry to an ABI Rehabilitation centre. In some cases, such as with spinal cord injury, the treatment pathway could be to first attend the spinal cord rehabilitation unit and then to enter the brain injury rehabilitation unit. In such cases, brain injury education and support via in reach would be possible. Likewise, if the treatment pathway is to the brain injury unit first, other required specialist services can be accessed via in reach from there. The etiology, level or completeness of the spinal cord damage will factor into the clinical decision making but not be the determining factor. Collective decision making between the providers, funders and whānau occurs to determine the best rehabilitation pathway for the individual.

FUNDING AND REFERRALS

ABI Rehabilitation accepts referrals from private individuals, ACC, District Health Boards, the Ministry of Health and a range of medical insurers. Rehabilitation services generally funded include therapies, treatment, nursing care, accommodation, laundry and food. Personal items such as toiletries are not funded. For clients that receive funding, there may be some items that are not included or have a co-payment such as certain medications or dentistry. Any items that are not funded are discussed with the client and their family/whānau.

ACC Funding

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

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

This TBIRR contract is for people aged 16 years and over who have sustained a moderate to severe brain injury with an accepted ACC claim. 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 some residential nights if required.

Typically, clients are referred following an initial period in a public hospital. However, community-based clients may also enter this contract with ACC case manager approval. The TBIRR contract specifies geographic boundaries (North Island), but we can accept clients from outside this area if requested.

Some large employers are accredited employers who use a third party insurer for ACC related claims. ABI Rehabilitation works with these insurers to provide equivalent services to the TBIRR contract.

MOH and DHB Funding

Following a referral, ABI Rehabilitation will complete a pre-admission assessment and determine the appropriateness of each referral. Referrals are typically for those with brain injuries not covered by ACC or for people who have suffered a stroke or present with another acquired neurological condition.

Private Insurers

ABI Rehabilitation has arrangements with several private health insurers. This enables ABI Rehabilitation to provide its full range of services to many people with medical insurance.

Private Funding

For privately funded services, please contact an ABI Rehabilitation service manager to discuss a quote.

SEAMLESS TRANSITIONS

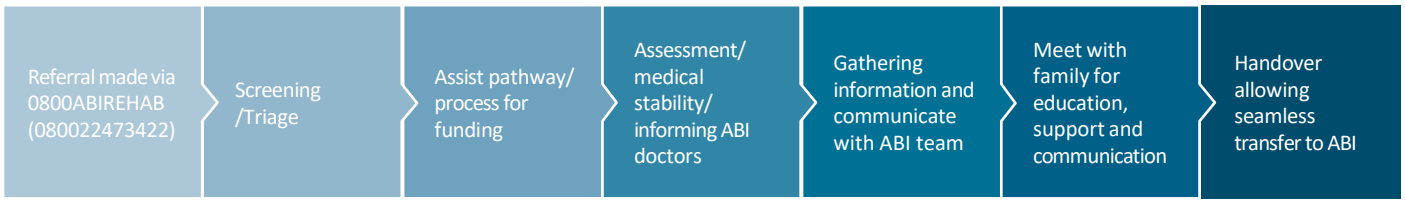
Admission

ABI Rehabilitation has admission and exclusion criteria for those requesting rehabilitation services. These criteria relate to contractual eligibility, medical stability and the individual's ability to benefit from rehabilitation.

Those with an accepted ACC claim for a moderate to severe TBI can access the intensive inpatient services directly from the public hospital (DHB) or from the community. If entering services via the community or the Emerging Consciousness programme, ACC approval is required. Currently, all non-ACC referrals require prior funding approval. Admissions may be for 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 includes working with the families-whānau and clients to provide education about brain injuries and their potential pathway. They work closely with the ABI Rehabilitation team to provide up to date information surrounding the health and rehabilitation status of the client to ensure a seamless transfer to the inpatient rehabilitation unit.

Brain injury Nurse specialists oversee the transition from hospital to the inpatient service.



Discharge

Discharge planning commences from the day of entry to an intensive rehabilitation programme. The 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 support available to a client.

The discharge process includes involvement from the client, their family/whānau, funders, the rehabilitation team, and where necessary, the accepting community provider(s). The process varies between clients as they have individual needs and situations. Each client has a keyworker, who acts as a link between the rehabilitation team, funder, client and the client's family/whānau. The keyworker coordinates the discharge process. There is typically at least one discharge planning meeting before discharge occurs. There may be a home visit or assessment prior to discharge to assess environmental needs and make equipment recommendations as appropriate. The interdisciplinary team also makes recommendations to the funder to support a client's discharge and rehabilitation needs required following it.

ABI Rehabilitation is able to provide support for clients following discharge. This may include medical reviews, support or education to the family and/or carers on brain injury matters or to assist with rehabilitation plans. If needed, ABI Rehabilitation also provides community-based rehabilitation for anyone discharged from its service.

Discharge Criteria

Discharge criteria varies depending on the client's presentation and family/whānau needs. Prior to discharge, the rehabilitation team will assess each client's continuing rehabilitation needs and will confirm if rehabilitation in a specialised intensive rehabilitation setting is no longer required. Discharge may be back to a client's home, family member's home, residential rehabilitation setting or to a higher level of nursing care (such as a rest home or private hospital). Over 85% of clients entering the intensive rehabilitation service are discharged to their home.

Transition to Home

Returning home can be an exciting time, but it is important that the right steps are taken. To maximise the success of this key phase, clients are likely to 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 are likely to arise upon discharge so that they can be prevented. When having home leave, clients are sent home with an information sheet that is relevant to them. It outlines rehabilitation activities and potential risks related to the home environment. Included is a section for the client and family/ whānau to provide feedback following the leave period.

As part of discharge planning, recommendations and handovers are provided to the community-based rehabilitation teams to enable continued rehabilitation in the community. This process includes the ability for clients and their families/whānau to meet with the community providers before discharge.

Transition to Other Facilities

There are times when a client no longer needs intensive rehabilitation, but their recovery means they are not ready to return home. In discussion with the client and their family/whānau and funder, a referral may be made (from the funder) to one of the residential rehabilitation services, rest homes or private hospitals in a client's local area. In these situations, the client and their family/whānau are encouraged to visit the other services beforehand, if possible. A full handover process helps any onward providers to continue rehabilitation activities when a client moves to another facility.

Contact Intensive:

AUCKLAND: **+64 9 831 0070**
WELLINGTON: **+64 4 237 0128**

Residential Services

The residential rehabilitation services in Auckland and Wellington offer clients comprehensive 24-hour residential support. The service enables clients to attain the best quality of life through client-centred activity programmes, including slow-stream rehabilitation and recreation within a community setting. The client, their family/whānau, the funder and ABI Rehabilitation staff meet regularly to review the current rehabilitation plan, particularly if it is likely that the client may be able to return home following slow-stream rehabilitation.

Rehabilitation goals, as appropriate, form part of the plan. These goals focus on increasing community participation and improving functional ability e.g. improving communication, mobility, or behaviour within community settings. The plans and support may also involve life skill activities such as community sports and volunteer or supported employment work.

Outings in the community are encouraged, including regular trips to libraries, community centres, Sailability Auckland, Riding for the Disabled, churches, parks, gyms, cafés etc. One-off activities also include trips to the zoo, the city, rugby games, mini golf courses, museums etc.

Family/whānau are encouraged to participate in ABI Rehabilitation-based activities and client visits to the family home are facilitated. When appropriate, clients may visit each other for social morning teas, BBQs and to play pool, basketball, bingo and other games.

The service enables clients to attain the best quality of life through client-centred activity programmes, including slow-stream rehabilitation and recreation within a community setting.

STAFFING

ACCESS TO SERVICE

The programme is available to anyone over the age of 16. Referrals are typically from ACC or the Ministry of Health for clients with TBI, stroke or other neurological impairments who cannot live independently in the community.

Should the individual have spinal cord damage in addition to their acquired brain injury there would need to be a pre-admission risk assessment to ensure their care and rehabilitation needs could be met. The etiology, level or completeness of the spinal cord damage will factor into the clinical decision making but not be the determining factor. Collective decision making between the providers, funders, Client and whānau will occur to determine if ABI Residential Services will meet their needs.

On receipt of a referral from the funder, a pre-admission assessment is conducted. If appropriate, admission details are planned in consultation with the client, their family/whānau, the funder and ABI Rehabilitation.

The service supports clients who are in a minimally conscious state and require full assistance with all day-to-day activities, through to those who may be discharged and regain independence.

SETTING OF SERVICE

There are five houses with a total of 35 beds situated across the West Auckland community. The houses have been modified and equipped as appropriate. For example, there are wheelchair accessible houses and a house in a more secure environment for clients who are cognitively impaired. Clients are allocated a house according to their specific medical and rehabilitation needs.

Each resident is encouraged to personalise their own room, and all houses feature a lounge, dining area and kitchen. Generally, all meals are prepared by staff in the kitchens on-site. Each client's dietary and cultural food requirements are met as they have the opportunity to get involved in meal planning and preparation.

In Wellington, residents have rooms within the rehabilitation centre at Hospital Drive, Porirua. They have access to the on-site laundry, kitchen and gym facilities.

DISCHARGE FROM SERVICE

Where appropriate, discharge/transition from residential services to more independent living is encouraged and supported. In order to provide the best support to a client and their family/whānau, ACC case managers and/or the Needs Assessment and Service Coordination (NASC) service are involved in the discharge process, as are the rehabilitation team and GP as indicated.

Contact Residential:

AUCKLAND: **+64 9 836 4860**
WELLINGTON: **+64 4 237 0128**

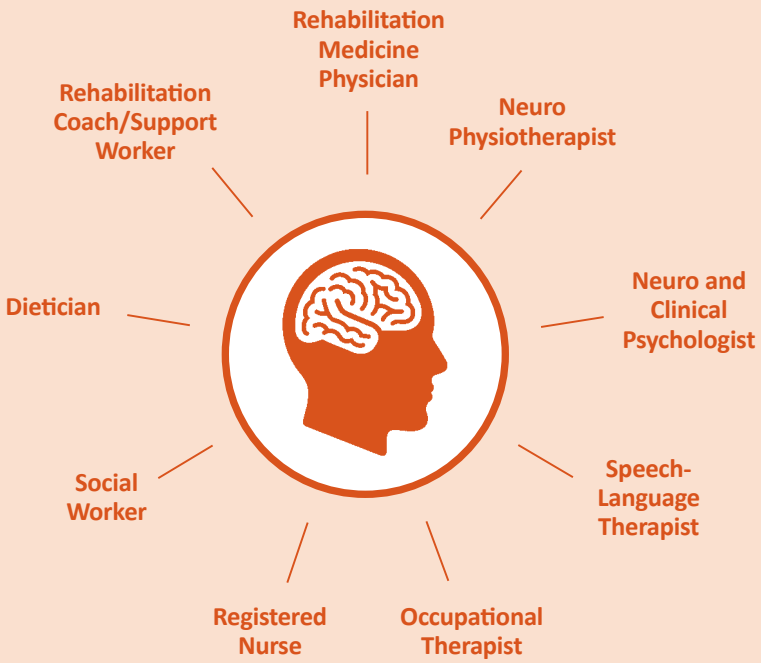
Community Services

SERVICES/PROGRAMMES

ABI Rehabilitation provides specialist services for both adults and children through its community services, which include assessments, treatment and therapy programmes. Services are delivered by a range of reliable and compassionate professionals.

The community rehabilitation team covers a wide range of injuries from mild to severe traumatic and hypoxic brain injury through to fractures.

The interdisciplinary team includes:



Please contact an ABI Rehabilitation Community Service for information about the services on offer and other external agencies that may be able to offer advice and support.

With treatment-based services, rehabilitation is planned following an assessment of each client's rehabilitation needs. Clients often need to receive services from more than one of the ABI team members e.g. a physio and an occupational therapist. The interdisciplinary team works with each client under the guidance of a keyworker to assist with the coordination of rehabilitation. This ensures each client receives a seamless specialist service with great outcomes.

SERVICE FUNDING

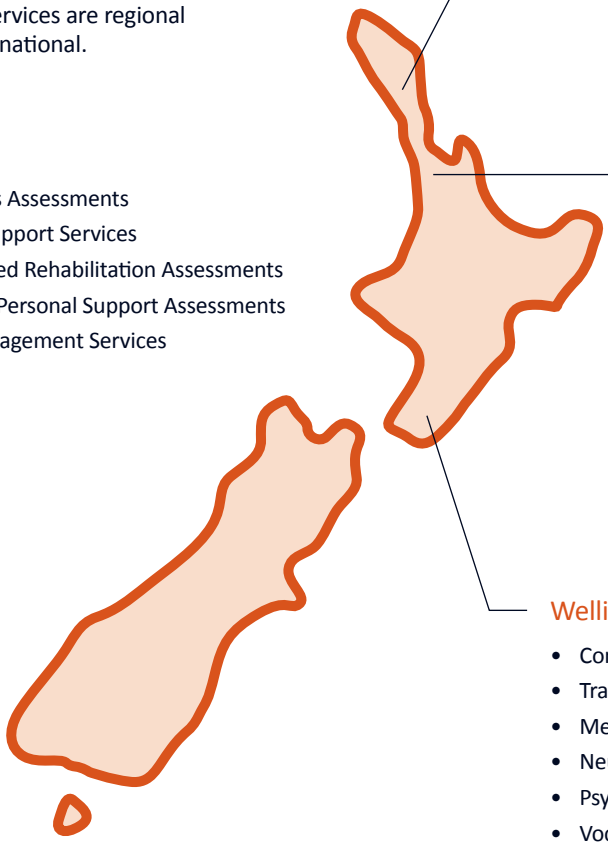
The majority of the contracts held are fully funded under ACC. However, there are non-ACC services available.

ACC

Some of these services are regional while others are national.

National

- Support Needs Assessments
- Behavioural Support Services
- Education-based Rehabilitation Assessments
- Retrospective Personal Support Assessments
- Spasticity Management Services



Northland

- Concussion Services
- Training for Independence Services
- Concussion Services
- Training for Independence Services
- Medical Specialist Assessments
- Neuropsychological Assessments
- Psychological Services
- Vocational Services

Auckland

- Concussion Services
- Training for Independence Services
- Medical Specialist Assessments
- Neuropsychological Assessments
- Psychological Services
- Vocational Services
- Social Rehabilitation Needs Assessments
- Initial Occupational Assessments
- Vocational Medical Assessments
- Specialised Wheelchair and Seating Assessments

Wellington / Wairarapa / Kapiti

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

Outpatient Stroke Rehabilitation

ABI Rehabilitation receives funding from a philanthropic trust, enabling it to provide a community-based stroke rehabilitation programme. This programme is delivered in Auckland 2-3 times per week over a 8-12 week period and is led by a physiotherapist specializing in neuro-rehabilitation. The content of the programme is based around education and exercise to regain function and build confidence following a stroke.

Other Non-ACC

Private

There is the ability for anyone wishing to access the services to self-fund. Please contact your local ABI Community Service to explore this option.

Other Private Agency

ABI Rehabilitation is able to provide a range of therapy services to other agencies requiring or funding rehabilitation. ABI Rehabilitation currently supports clients via Oranga Tamariki, the Ministry of Education Intensive Wraparound Services (IWS) and the Minsitry of Health. Please contact ABI Community Service to find out more.

SETTING OF SERVICE

The **Auckland** community services are based out of three office sites in Central, South and West Auckland.

The clinic buildings at Grafton, Botany and NorthWest Shopping Centre are accessible for all people, close to public transport and have plenty of free parking. There is also a satellite clinic in Northland.

Community services also include visits to client's homes, school or work.

The **Wellington** community service is based in Tawa. The building has good access and is close to public transport (buses and train). There are also satellite clinics in Masterton, Lower Hutt and Paraparaumu.

The interdisciplinary team visits most of their clients in the community as the focus of the community service is to support clients to return to independence in their homes, schools, workplaces 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 any appointments.

Community services also include visits to client's homes, school or work.

ACCESS TO SERVICE

Referrals can come via ACC, GPs or clients themselves. However, prior to an assessment, funding approval is required.

To make a referral, please send a referral letter to communityreferrals@abi-rehab.co.nz

OR

Please contact ABI Rehabilitation Community Services on 09 3737850 (Auckland) or 04 240 0122 (Wellington) with any questions.

DISCHARGE FROM SERVICE

Being discharged from ABI Rehabilitation Community Services means a client has reached a pre-determined level of independence with either work, home, school and/or community activities.

There are some ACC funded services that are a "one-off" assessment, so clients may be discharged after one episode or intervention (i.e. independent occupational assessments, neuropsychological screens, etc.).

The interdisciplinary team visits most of their clients in the community as the focus of the community service is to support clients to return to independence in their homes, schools, workplaces and communities.

Contact Community:

AUCKLAND/Grafton:	**+64 9 3737850**
AUCKLAND/Northwest:	**+64 9 826 4004**
WELLINGTON/WAIRARAPA:	**+64 4 240 0122**

Paediatric Services

Contact Community:

AUCKLAND/Northwest: **+64 9 826 4004**
Wellington: +64 4 240 0122

ABI Rehabilitation Community Services have an allied health team who are experienced and specialised in working with children with developmental concerns, disabilities and acquired injuries.

We provide assessment and treatment for a variety of conditions including:

- Developmental delay
- Cerebral palsy
- Concussion
- Brain injury
- Dyspraxia
- Spinal cord injuries
- Spasticity
- Gait problems
- Speech delay
- Fine motor skill development
- Managing sensory or emotional/behavioural needs

We assist children and their family/whānau from birth through to leaving school, using a family-centred model of care, that recognises you as the expert in your child's care and our team as expert partners supporting your goals and aspirations.

Our professional team includes occupational therapists, physiotherapists, speech- language therapists, dieticians, social workers, nurses and psychologists.

We accept referrals from ACC and other funding agencies and also welcome enquiries for privately funded services.

For further information, please contact the Northwest branch of ABI Rehabilitation Community Services.

Koru

New life, growth, strength

The meeting and the unfolding of a relationship, building trust, empathy, understanding and quality of the recovery journey.

ASPIRE to Excellence® carf ACCREDITED QUALITY PROVEN

abi

ABI Rehabilitation New Zealand Ltd

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09-831-0070 (Auckland) 04-237-0128 (Wellington)