

Care Pathways in Brain Injury Rehabilitation:

The view from a community Outreach Team

Professor Jane Powell

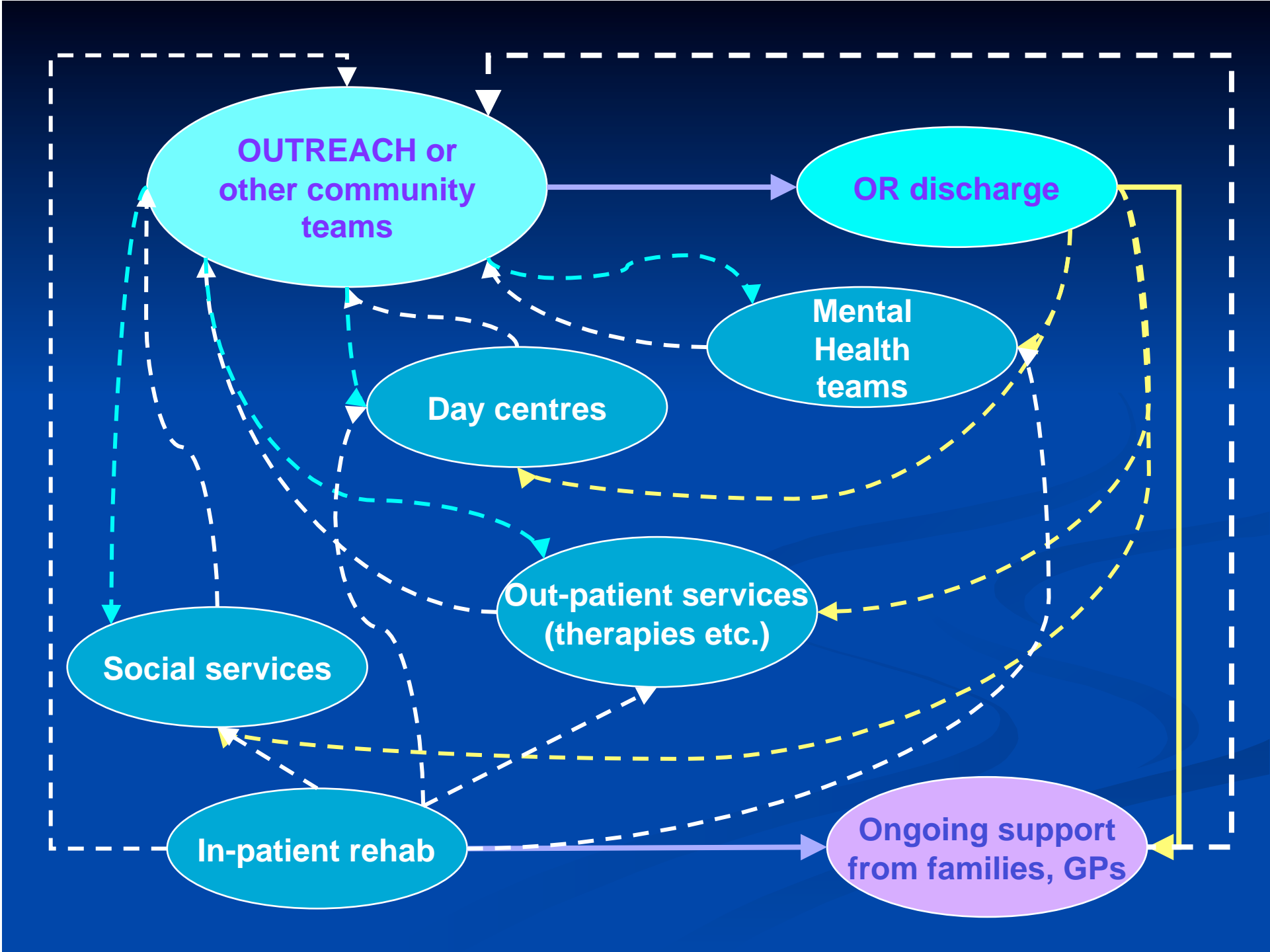
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How does the Outreach Team work?

Our interdisciplinary team comprises OT, physio, SLT and neuropsychology, and works with adults with ABI in community settings including their homes, day centres, and workplaces. We:

- Accept referrals from any source (client, GP, therapists, day centres, etc.) and clients across a wide range of functioning
- Take on clients at any stage post-injury (subject to funding)
- Work collaboratively with the client, his/her carers and family members, and any other health/social care agencies who are already – or should be – involved
- Offer time-limited input to achieve functional gains rather than providing long-term support. Input is limited by funding constraints.



Delays in referral



Potential benefits of a delay

- Person and family have had time to adjust, develop own resources, find out what the key problems are
- Psychological 'readiness' for more rehab

Potential problems

- Gains from previous treatment have not been maintained
- Some conditions may have worsened (e.g. physical mobility/fitness)
- Frustration, lack of encouragement/support, etc. may have
→ low mood, low motivation, family stress, development of behavioural problems
- Simple resources may not have been put in place, so potential not realised; 'wasted years'.

Community rehabilitation can help patients make gains however long they are post-injury and post-hospital discharge;

but scope for progress may be limited in some cases by 'lost gains' or deterioration

**Concurrent working
with other agencies**



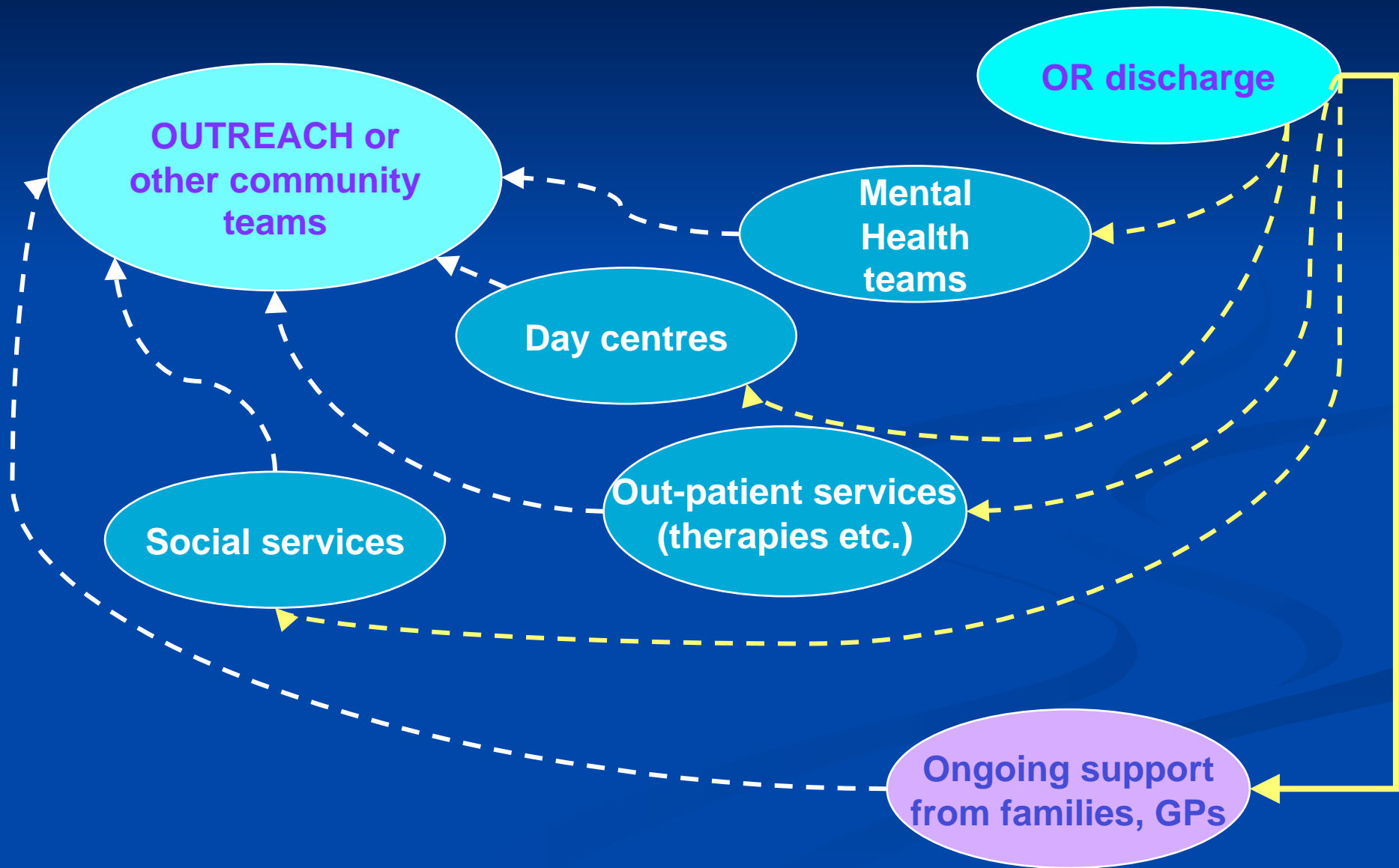
When good support is in place:

- Rehab can capitalise on these resources to yield maximal gains for client and family
- ... and can work with these agencies to refine and optimise their provision (may e.g. → reductions in ongoing care needs)

When it is not:

- Specialised rehab time is spent attempting to overcome problems over which we have little direct control
- Client cannot make potential gains because of lack of environmental or carer resources/support

DISCHARGE



Issues at discharge

Ideal: Good and appropriate care systems are in place, client is in suitably adapted accommodation, and has access to a range of appropriate vocational / educational / social facilities. Is able to maintain or even build on progress.

Inadequate or unstable care arrangements:

- Gains may be lost over time
- Even if care is subsequently put in place it may be inadequately supported or tailored to client's capabilities
- ... though subsequent re-referral to Outreach may enable this to be addressed

Lack of appropriate out-patient / community sources of support to maintain and promote functioning:

- Client loses some or all of gains made in community rehab
- May be re-referred at later date with similar problems