Croydon Health Services NHS
NHS Trust

Croydon Community Neurorehabilitation Team

Community Services for Head Injury

www.ccnrt.co.uk

Specialist community neurorehabilitation focusing on:

- Managing personal care
- Mobility
- Continence
- Communication
- Spasticity management
- Memory strategies
- Coping with disability
- Information and education
- Nutrition
- Psychological well-being
- Domestic activities
- Return to work and leisure activities
- Access to local facilities
- Computers and technology
- Getting back to a future

WHO definition of rehabilitation

Community-based rehabilitation (CBR) focuses on enhancing the quality of life for people with disabilities and their families, meeting basic needs and ensuring inclusion and participation. CBR was initiated in the mid-1980s but has evolved to become a multi-sectoral strategy that empowers persons with disabilities to access and benefit from education, employment, health and social services.

Rehabilitation is about getting

- Back to a Future

Specialist services

- Physiotherapists
- Occupational therapists
- Speech and language therapists
- Clinical neuropsychologists
- Rehabilitation assistants

- CCNRT up to 14 weeks intensive
- Community intermediate care, crisis management
- Longer term monitoring, advice to carers.

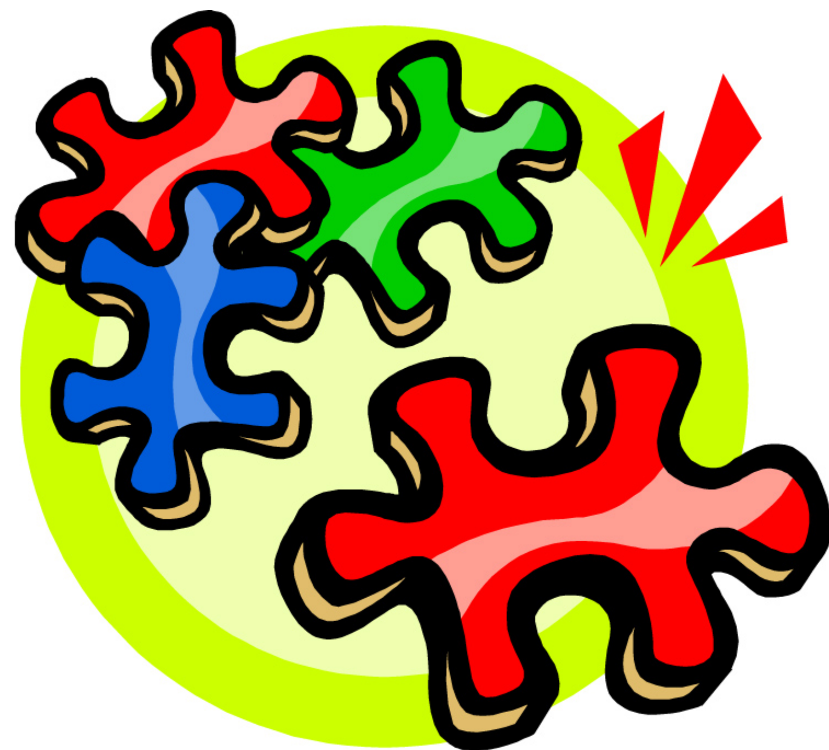
Croydon Community Neurorehabilitation Team

- Set up 1994
- Wide area of expertise
- Experienced staff with over 150 years in neurorehab
- Centre with gym and clinic rooms
- Patients seen at Broad Green Centre, at their home, around the community, public transport and at their workplace

Criteria for admission

- Croydon GP
- Medically stable
- Safe to be at home
- Can benefit from short term, intensive therapy
- Motivated and able to participate in therapy programme
- No psychiatric disorder that would prevent them from making progress
- No dependency on drugs or alcohol

Assessment of Need



Rehabilitation Needs Assessment

Benefit for the patient and family

- At the patient's home
- Within a week of referral completed by therapist
- Therapist explains process through the service
- Provides patient and families with information
- Patients and families can ask questions
- Other services involved
- Express their expectations

Benefit for the team

- Medical background and co-morbidities
- Gathers information about current needs and any previous rehab
- Information about background and interests
- Able to ascertain level of need and priority
- Framework to develop an individualised programme

Process for therapy

- Ambulance transport system for bringing them to the centre
- Patients seen within 4 weeks of assessment
- Attend 4 to 12 sessions a week depending on need – up to 14 weeks
- Patients receive appointment sheet each week
- Goals set within 2 weeks
- Family meetings after assessment and before discharge
- Review goals every 2 weeks
- Discharge plans discussed once initial assessment completed
- Patient profile of strategies and useful personal information
- Written information on brain injury

Process for Therapy

- Goal Attainment Scale
- Quality of Life Scale
- (Brain Injury Community Rehabilitation Outcome)
- Group therapy, active hands, communication, relaxation, exercise
- Brain injury education groups on memory strategies, mood and problem solving
- Specialised computer software
- Discharge packs

Case Study 1 Medical History

- Wound to head involving left parietal and frontal regions
- Removal of infected bone flap
- Decompression craniotomy
- Cranioplasty

Pathway through services

- King's College Hospital
- Mayday Hospital
- Wolfson Medical Rehabilitation Centre
- Mayday Hospital
- CCNRT

Initial difficulties- impairments

- Right side paralysis
- Reduced sensation on right side
- Limited understanding of speech
- Low mood
- Difficulties with personal care
- Impaired memory
- Poor problem solving
- Impaired maths and money skills

Problems and strengths

Participation problems

- Help with personal care
- Limited daytime activity
- Limited motivation
- Limited physical activity- not going to gym
- Unable to express needs- unable to express more than basic information
- Limited reading/writing ability- unable to manage post or budget

Strengths

- Mother returned from abroad to care for him initially
- Beginning to make improvements

Goals

- To attend a gym once a week
- To prepare light meals
- To be independent in personal care
- To manage daytime activity
- To use writing to assist communication
- To read and sing rap songs
- To manage money
- To use public transport
- To dance simple rhythms
- To enrol in music study class

Discharge-ongoing achievements and difficulties

- Attended 2 episodes of 14 weeks
- Achieved most goals
- Increase in confidence and more outgoing
- New girlfriend and baby
- *Reliant on father for managing money*
- *Accommodation problems*
- *Not attending gym*
- *Unable to pursue music as an interest*
- *Very limited daytime activity*
- *Limited social network*
- *Needs a buddy to help plan and organise*

Case study 2 - History

- Glasgow Coma scale of 6 out of 15 on admission
- CT scan showed diffuse axonal injury
- Whilst in ITU he was intubated, required a tracheostomy, and a urinary catheter was inserted
- Whilst in a coma he pulled this out causing a urinary stricture

Problems

- Current activity mainly involved watching TV, and playing computer games
- There had been a number of incidents of patient losing his temper; shouting at family
- Reported feeling that "life is useless now"

Psychological issues

- He was especially upset about not being allowed to drive and his on-going urinary difficulties
- Repeatedly asking different members of the team about returning to drive
- He threatened to obtain heroin and to take an overdose
- He was independently mobile although some minor difficulties with balance

Goals

- To complete a programme to return to work
- To complete a gardening project
- To use public transport around Croydon
- To participate in domestic activities
- To use strategies to manage anger
- To use computer to plan activities

Return to work

Put in touch with DEA
Retraining?
Vocational rehab?

Refused all of these options and would only consider returning to work with his father

A graded return to work was facilitated

Activities limited due to balance problems

At time of discharge was working 2-3 days a week

Using public transport

Initial journeys to and from the centre with support worker

Very reticent to progress from these

Insisted he did not and would not used public transport

Focused on return to driving

Both he and his father were given information on return to driving following a head injury

Despite this he repeatedly asked different team members when he could drive his car

Developed a consistent approach amongst all those who worked with him

What future?

NSF - Quality requirement 1 - Person centred

- Interdisciplinary team
- Housed in one centre
- One overall team leader
- Joint care plans
- Evidence of achievements
- Referral to appropriate agencies
- Close liaison with social services
- Ongoing psycho-educational groups

NSF quality requirement 5 Community Rehabilitation and Support

- Multidisciplinary rehab needs assessment
- Specialist team close to patients' homes +
- Co-ordinated team
- Goal orientated therapy
- Support to family and carers
- Strong links with other services e.g inpatient units
- Co-ordination of health and social care
- Wider participation including leisure and work

NSF Quality requirement 6- Vocational Rehab

- Provide facility to prepare for work
- Close links with Disability Employment Advisor
- Guidance on starting voluntary work
- Advice to employers
- Support back into education
- Practical support in the workplace initially

Gaps in the service

- Ongoing daytime resource for advice and support
- Buddy system
- Staff available to provide reviews and revise goals
- Support for families and ongoing issues
- Support for further education
- Support for social interaction
- Support for ongoing financial, social, emotional issues
- Suitable work for people that need extra support
- Funding for further vocational rehab
- Headway group being taken forward
- Croydon Employment and Support Service 1 year + wait