



St Andrew's
HEALTHCARE

Kemsley, National Brain Injury Centre

What we do and where people go afterwards

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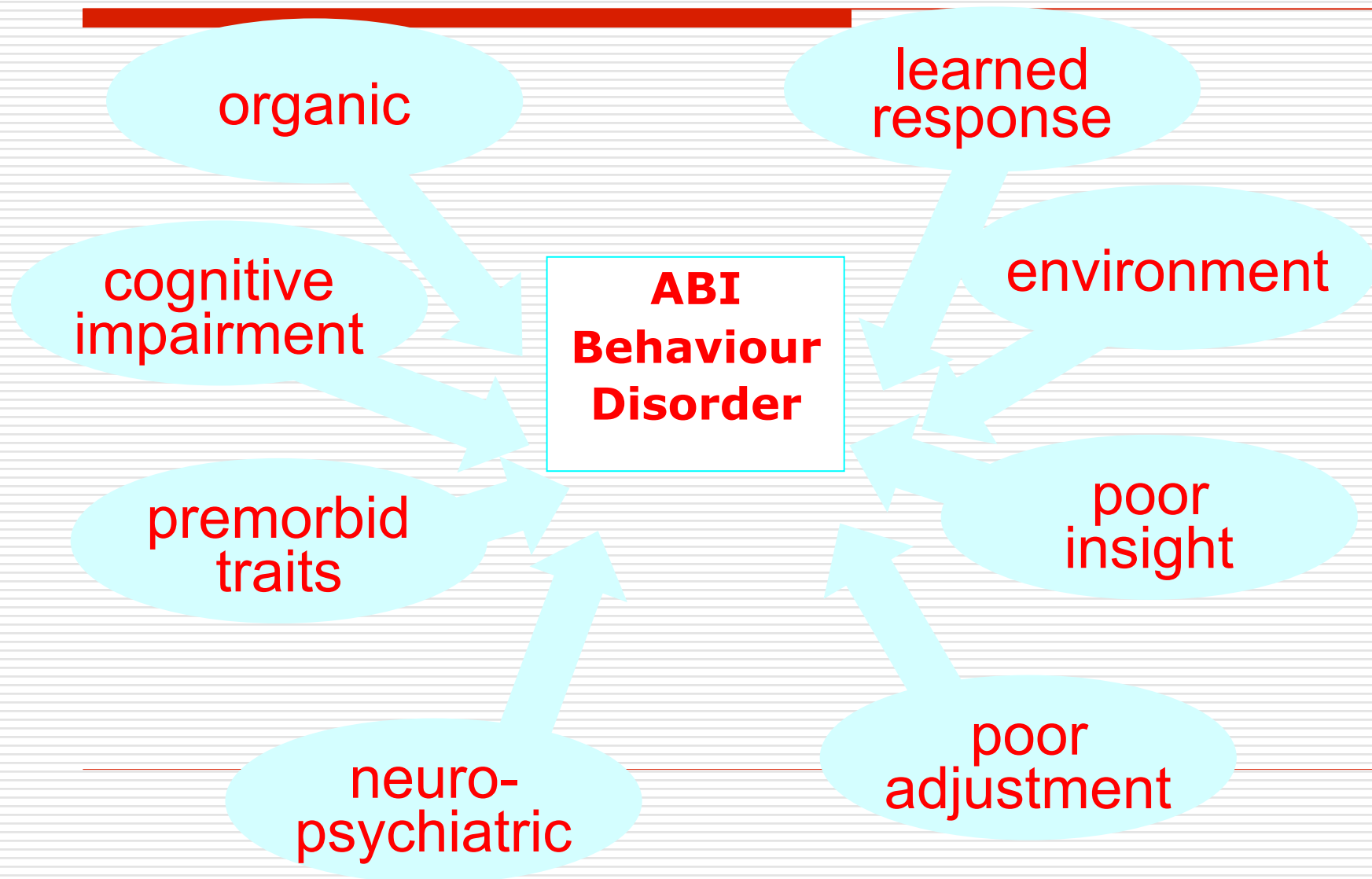


ST ANDREW'S HEALTHCARE
LEADING THE WAY IN
BRAIN INJURY SINCE 1979

Psychosocial and behaviour changes associated with an acquired brain injury

- disregard of social rules**
 - lack of inhibitory control**
 - physical aggression**
 - verbal aggression**
 - oppositonality**
 - shouting, screaming**
 - sexual disinhibition**
 - passivity**
 - low arousal**
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The factors to address



The facilities



Neurobehavioural Rehabilitation Units

East/West

Each of 12 beds, rehabilitation for adult males with the most difficult to manage behaviour

South West

12 beds and 2 self-contained flats, for adult women with a range of behavioural control and rehabilitation needs

South East

16 beds (including 5 individual flats) for adult males in the later stages of rehab and possibly preparing to rejoin the community

Longer-stay neurobehavioural units

South

14 beds for adult men who require on-going secure support in the long-term due to ongoing behaviour disturbance. Building upon individual's strengths to maintain rehabilitation gains and enhance quality of life.

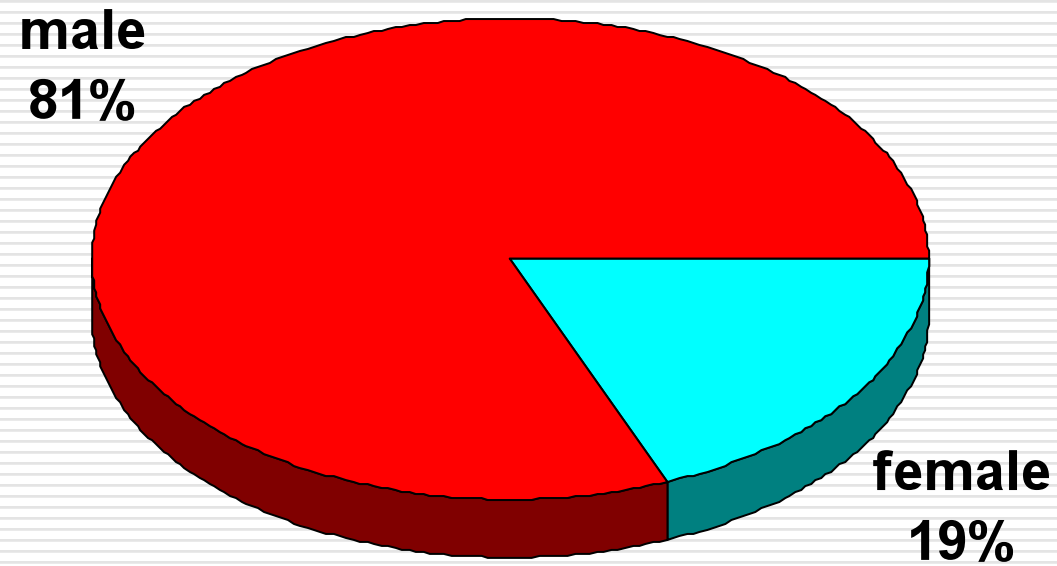
32a Berkeley Close

Specialist residential service located within a local housing estate adjacent to the St Andrew's campus. Providing a service focussing upon community reintegration for up to 24 men and women who may have previously completed a rehabilitation programme but still require structure and support.

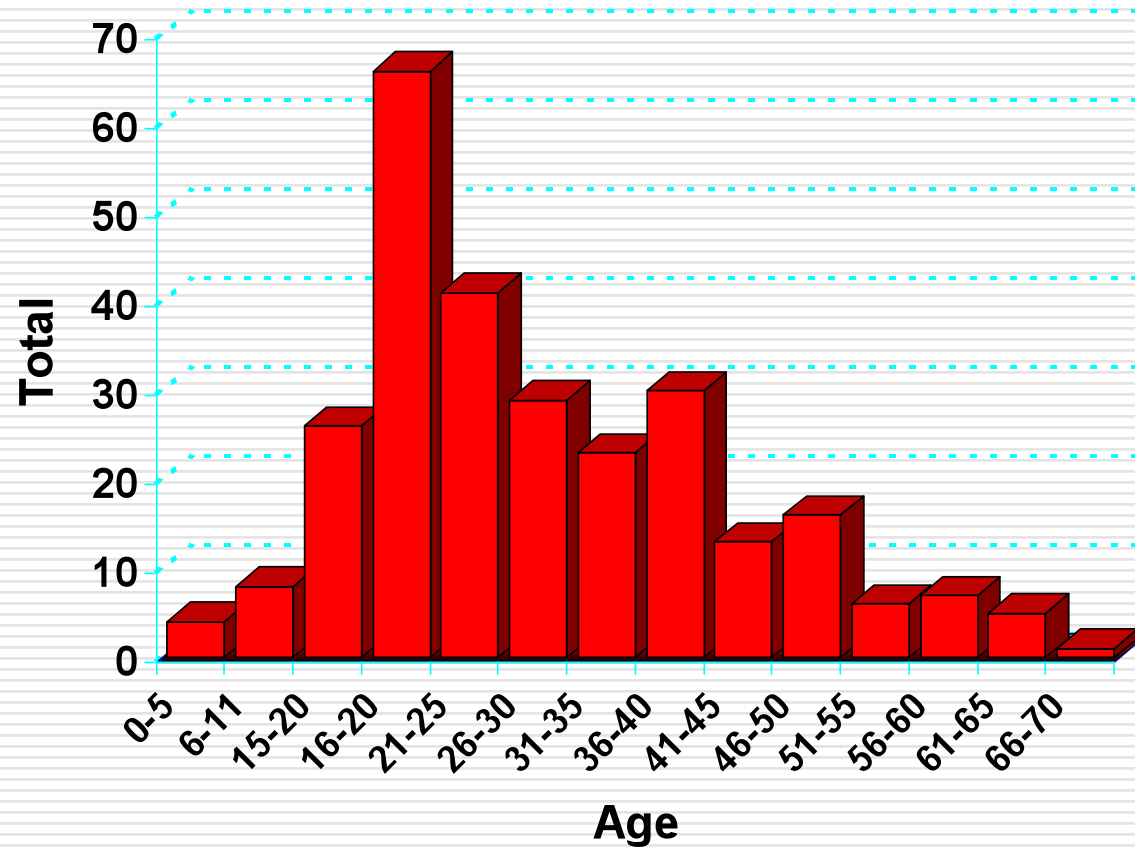
Berkeley Lodge

6 bed specialised group home

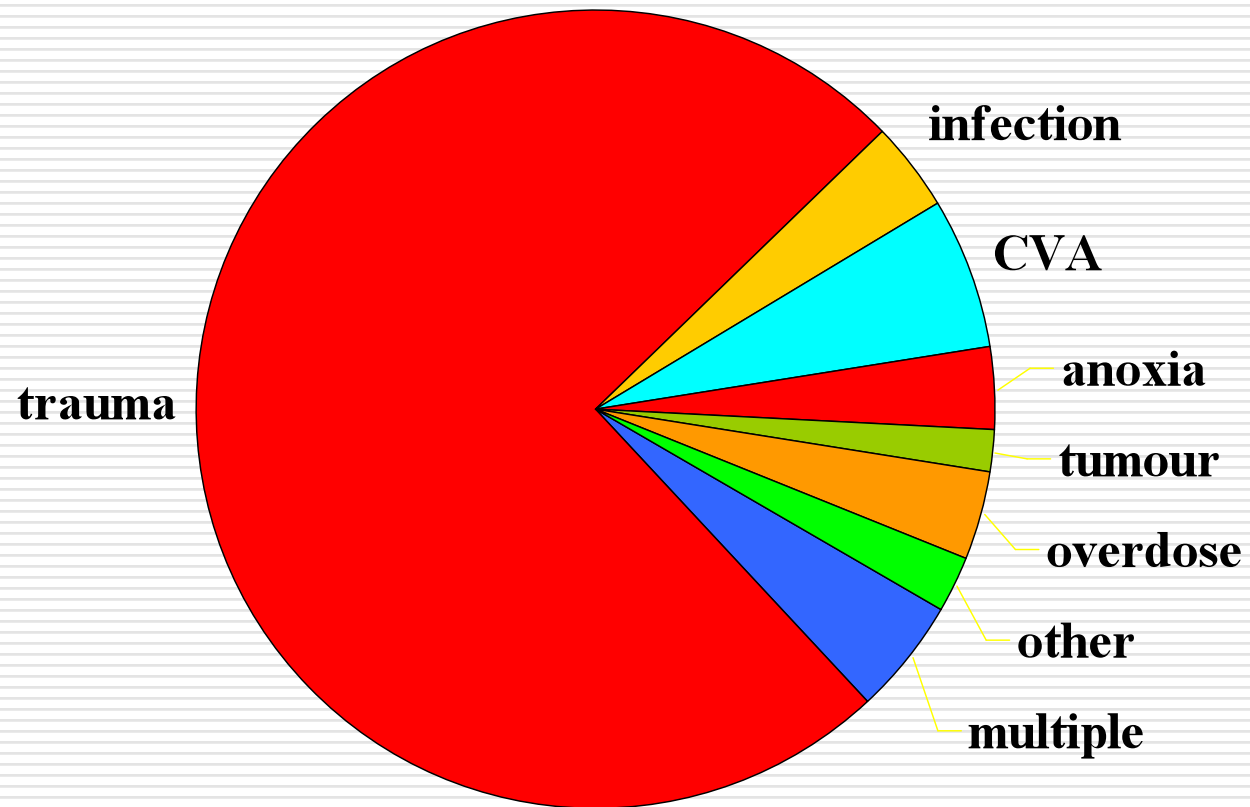
Breakdown of admissions by gender



Age at time of injury



Cause of brain injury



The neurobehavioural approach to rehabilitation

Draws upon:

Neuropsychology

Behaviour Modification

Social Psychology

Behavioural Neurology

Combined to promote acquisition & spontaneous use of functional & social skills that negate social handicap arising from neurobehavioural disability

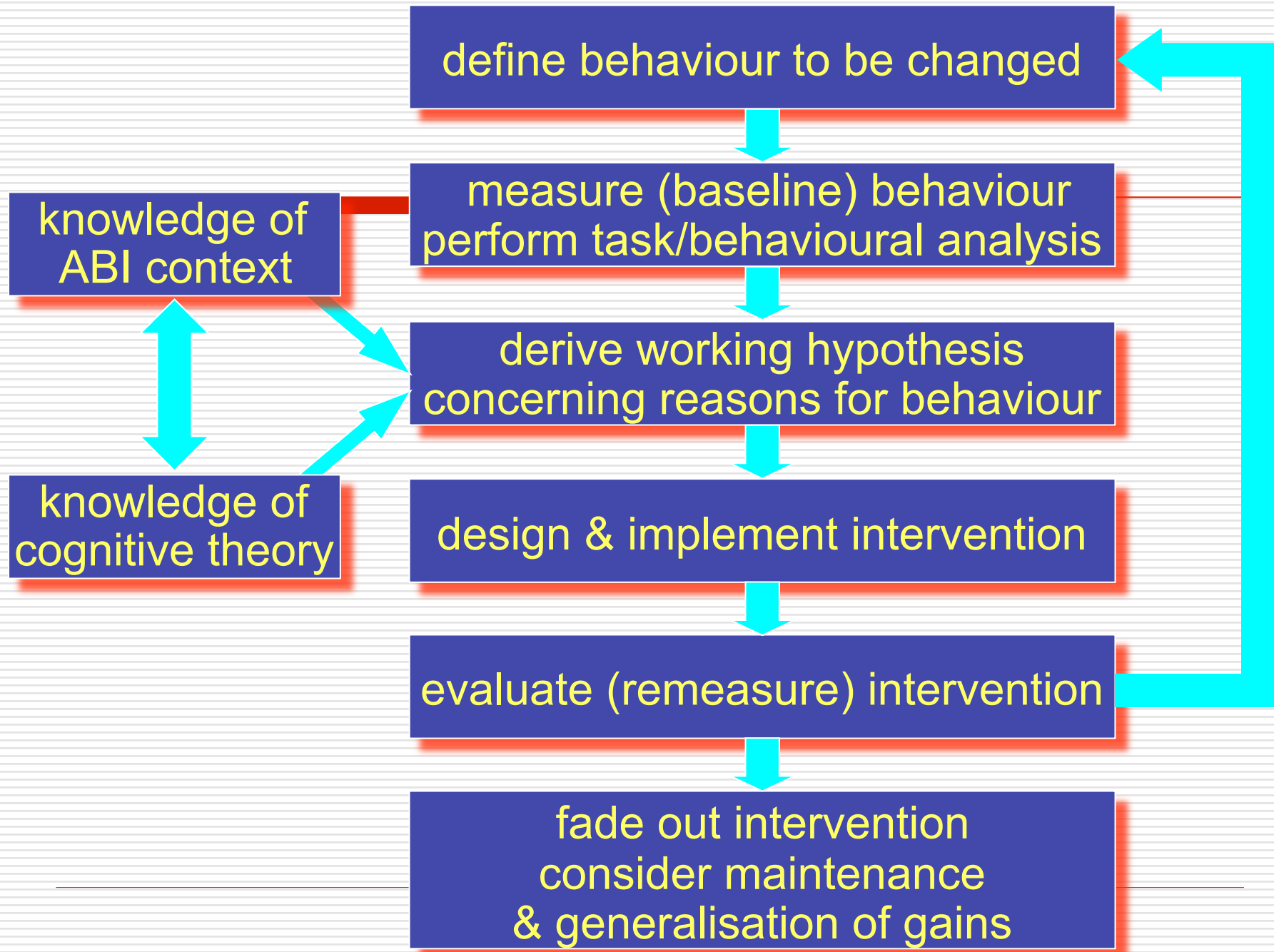
Neurobehavioural rehabilitation comprises a 2-component system (Wood, 1990)

- (1) A structured environment that creates conditions that facilitate inhibition of behaviour disorders

 - (2) A system that promotes learning to:
 - increase awareness
 - improve motivation
 - shape behavioural responses into an acceptable form
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Behaviour Change Through

- ❑ Reinforcement of appropriate, desirable behaviour
 - ❑ Extinction of undesirable, inappropriate behaviour
 - ❑ Use of individual reinforcer programmes
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Key role of feedback

- Spontaneous
 - inconsistent
 - vulnerable (person dependent)
 - danger, may reinforce undesirable behaviour (e.g. "...don't do that!")

 - Programmed
 - consistent
 - less vulnerable (team approach)
 - reinforce desirable behaviour whilst giving appropriate feedback regarding undesirable behaviour
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- Behaviour management techniques change the behaviour of those people working with the service user
 - The neurobehavioural rehabilitation framework provides a framework that acts as a brain prosthesis that can then become internalised
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Life beyond the National Brain Injury Centre (NBIC)

"If Carlsberg provided aftercare...."

The Aftercare package

What's so complex about discharge,
When you know what you want?

All he needs is

- ❑ A small community unit (24-hr support)
 - ❑ Boundaries and structure, definitely!
 - ❑ Someone to manage his finances (he's a bit vulnerable)
 - ❑ He can wander at times (hates being in care), so he may need somewhere with a locked door policy.
 - ❑ Every now and again he can get aggressive or verbally abusive (doesn't mean it though). Although he did hurt that nurse last month.
 - ❑ Oh yeah, he can make the odd sexually inappropriate comment to females. Although he has only touched on a few occasions.
 - ❑ He sees his kids regularly (supervised by a Social Worker)
 - ❑ You will need to watch him in the community, he likes a beer.
 - ❑ Oh yeah, forgot to say he's on Section 3!
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Now, If Carlsberg provided aftercare.....

It would be this simple!!!!

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1. A **common goal would be shared**, with the Service User, family and Associated Professionals all working together.
 2. The home area would have an **abundance of placements**.
 3. There would be **no need to make referrals** because local teams will volunteer services and want to be involved.
 4. The Service User would be assessed by **several placements** and deemed suitable by all.
 5. The Service User would visit all placements, and choose their favourite, **irrespective of the cost**.
 6. The chosen placement would **meet all identified needs**, have a plasma TV in every room, 24-hour waiter service and an annual three week holiday in Fiji.
 7. Funding would get **instantly approved**.
 8. The Service User would set a **transfer date that suits them**.
 9. Service User would **remain stable**, and transfer within 3-4 weeks.
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Unfortunately..... they don't

We do,
with lots of support !!!

The Service User... The Ward Clinical Team...The
Mental Health Team... Solicitors.. complex care
teams...MAPPA...Housing.....Case Managers.....
Benefits.....Family...Victim issues.....Funding
Panels...Risks...Identify placement..... Support
worker.....Social workers.....Responsible
Clinicians... Care co-ordinators... Community
resources... Physical Disability Teams.....
.....Brain Injury Teams... Safeguarding Adults
Team.....Probation.....Psychiatrist.....
Psychologist.....

Admission to discharge Patient-A

- ❑ Physically and sexually assaulted at home
 - ❑ sustained fronto-parietal subdural haematoma
 - ❑ Post-traumatic amnesia
 - ❑ Made good physical recovery
 - ❑ exhibited cognitive and behavioural problems, including verbal and physical aggression after one week
 - ❑ Became unmanageable due to level and frequency of aggression
 - ❑ Admitted to NBIC 30TH April 2008, under Section 2 and placed on Section 3 on the 8th May
 - ❑ Due to aggression, placed on 2:1 observations.
 - ❑ Between the 28.4.08 and the 29.9.08, she accrued 616 behavioural recordings of physical and verbal aggression.
 - ❑ Started to respond to treatment, recordings dropped significantly and discharged from Section on the 31st October 2008
 - ❑ In November 2008, recommendations were made by NBIC to identify suitable placements within the home area.
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Patient A

- December 2008, placement identified.**
 - January 2009, no available beds**
 - March 2009 still no beds. NBIC question the suitability of the placement in line with patient's progress.**
 - May 09, new placement identified.**
 - August 09, patient visits the potential placement. Deemed suitable.**
 - September 09, funding declined**
 - September 09, Alternate placement suggested (Huntington's Unit)**
 - September 09, patient visits placement. Deemed unsuitable.**
 - NBIC writes a detailed report with clear recommendations on which placement we consider most appropriate.**
 - October 09, funding declined once again.**
 - October 09, Original placement re-visited with the addition of a comprehensive bespoke package.**
 - November 09, funding declined.**
 - December 09, decision appealed, funding declined.**
 - December 09, case file goes to the Director of local services to make final decision.**
 - January 10- no further updates. Although legal advice has been sought.**
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This should have been a simple discharge,
especially with all these people in agreement

- Social Services
 - Community Care co-ordinator
 - Safeguarding Adults team
 - Family
 - Advocacy Service
 - Service user
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Patient B

- ❑ 1997- Complained of impaired vision.
 - ❑ Investigation eventually led to the diagnosis of a Craniopharyngioma (pituitary region tumour).
 - ❑ The tumour was removed on 22nd April 1998.
 - ❑ Rapid recovery and appeared well apart from residual left sided weakness.
 - ❑ Behaviour became increasingly difficult to manage with verbal and physical aggression displayed when not allowed free access to fluid and food.
 - ❑ Admitted to a Neurobehavioural Unit at Haywood Hospital in June 1998 with significant aggressive behaviours.
 - ❑ Continuous craving for food and exhibited obsessive rituals, mainly centred around cleanliness.
 - ❑ Discharged home in November 1999, extremely difficult to manage and a major risk to herself and others.
 - ❑ Admitted to NBIC February 2000.
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Progress.... the last ten years

- ❑ Active rehabilitation for 7-8 years.
 - ❑ Maintenance programme for 2-3 years, specifically aimed at improving quality of life.
 - ❑ Discharge options discussed at every CPA review.
 - ❑ Numerous placements identified; each deemed the patient unsuitable following assessment or following NBIC staff visiting the units.
 - ❑ New placement identified in January 2008.
 - ❑ Transferred to placement in July 2009.
 - ❑ Re-admitted to NBIC, within a week.
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Why?

Patient B has an extreme drive for food and an unquenchable thirst. Strict management is required with a daily allowance of 2100mls for all fluids, this is to maintain safe sodium levels . Simply being around food will cause her to lose concentration, become anxious and results in challenging behaviours such as aggression.

To safely manage her risks requires changes to the environment, which ultimately effects the whole client group.

How do we Manage this ?

- ❑ Patient B requires clear structure from the moment she wakes up.
 - ❑ Her fluids have to be controlled to 2100mls a day.
 - ❑ She has her own toilet (taps turned off)
 - ❑ All other patients toilets are locked off, requiring staff to open them.
 - ❑ Taps in her bedroom also turned off.
 - ❑ She uses wet wipes in toilet for her hands.
 - ❑ Access to areas such as the training kitchen and laundry are closely supervised. She is never allowed entry on her own.
 - ❑ Every activity needs planning down to the last detail, there has to be a plan on paper showing her the schedule.
 - ❑ If this includes food or drink, it has to be planned as to what she can have, in full detail.
 - ❑ Staff need to aware of risks in the community, such as stealing food such as chocolate and sweets.
 - ❑ On home visits, it is planned not to stop at motorway services, unless it is an emergency.
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Placement breakdown

- ❑ It took over six months to plan the discharge.
 - ❑ The environment was changed and adapted to cater for her specific needs/risks.
 - ❑ Staff from the unit spent over two months working with her before admission.
 - ❑ Every effort was made to re-create her programmes and structure.
 - ❑ Patient B was returned to NBIC following numerous episodes of challenging behaviour. The severity was so high that co-residents refused to leave their bedrooms.
 - ❑ The unit wanted to consider alternative options such as placing her in her own home with support.
 - ❑ This never materialised.
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Reality

- ❑ As a service, we admit the most challenging and complex of cases.
 - ❑ However, complex cases normally mean complex discharges and limited resources.
 - ❑ A majority will reach their optimal level of functioning and move on to a brighter future.
 - ❑ A few will reach their optimal level of functioning, and do not.
 - ❑ Whether it is due to a shortfall in resources or level of challenging behaviour, some remain with us for many years.
 - ❑ For those individuals, we continue to manage their risks, deal with the aggression and attempt to provide a good quality of life.
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Statistics

(The last 100 service users to leave NBIC, over four years)

- ❑ 69 transferred to alternative services.
- ❑ 29 returned back to their families/local area.
- ❑ 2 self-discharged against medical advice.