



# **WEST LOTHIAN COMMUNITY REHABILITATION & BRAIN INJURY SERVICE**

## **INTRODUCTION**

The West Lothian Community Rehabilitation & Brain Injury Service (CRABIS) is jointly funded (Health and Social Work Service) and now sits within the West Lothian Community Health & Care Partnership under Health Management. After a lengthy planning period, the Service was commissioned with the appointment of the Manager in December 1999. The Service was made available to clients from the beginning of February 2000.

## **THE AIM OF THE SERVICE**

To provide a coordinated rehabilitation service within the Community for adults with a physical disability and / or acquired brain injury working with clients to increase their level of functioning and participation thereby facilitating successful community integration and improving quality of life.

## **THE SERVICE**

A dedicated joint multi-disciplinary (AHPs – Occupational Therapists, Physiotherapists, Speech & Language Therapist and Psychologists employed through Health; Rehabilitation, Psychology, and Admin Assistants employed through Council) rehabilitation team provides physical and psychological rehabilitation within the home or community setting (e.g. assisting clients to access local sports facilities / shopping / transport / education etc.) to adults who live within the West Lothian catchment area, and fall into one of the following categories:-

- 1) Individuals discharged from hospital with complex needs e.g. following CVA
- 2) Individuals in the community with complex disability e.g. following CVA, MS, MND
- 3) Individuals with an acquired brain injury with cognitive, behavioural, emotional sequelae
- 4) Individuals who have suffered a mild head injury who have attended A & E at St.John's Hospital.

The majority of clients have a neurological condition and the members of the team have particular experience in the field of neuro-rehabilitation.

To be eligible for involvement from the service, the person must:

- Reside in West Lothian
- Be over 16 years of age
- Have the potential to improve his/her level of functioning
- Be medically stable
- If appropriate, have a pre-planned package of care in place and have all necessary equipment for discharge from hospital
- Be likely to require the service of two or more disciplines from the team, with the exception of clients with acquired brain injury and mild head injury who may require only one.

An initial screening assessment is carried out in the individual's home by a member of the Team. During this assessment the client and carer also identify the main difficulties and rehabilitation areas they may wish to address. The Team discusses the assessment in the weekly Team meeting and makes decisions regarding the required elements of the rehabilitation programme. It is likely that the client will be placed on the required waiting lists (Occupational Therapy, Speech & Language Therapy, Clinical Psychology, Physiotherapy) before commencing the rehabilitation programme. Waiting list prioritization is based on clinical risks. When intervention commences further specific assessment is likely and the goals of rehabilitation are then discussed and agreed with the client. Progress is generally reviewed every six weeks, with new goals being set at that time if rehabilitation is to continue. The client is discharged if all goals have been achieved, progress has plateaued and/or when clients have been linked into other resources which best meet their needs.

## **SERVICE ELEMENTS**

- Holistic assessment (personal and domestic activities of daily living, physical, cognitive, behavioural, emotional, social skills, speech/language/swallowing, lifestyle management, community living skills and employment issues)
- Rehabilitation in these areas and/or case management for individuals whose rehabilitation plan and goals have been agreed at the multi-disciplinary team meeting.
- Generic Rehabilitation Assistants contribute to the delivery of multi-disciplinary rehabilitation programmes, in conjunction with trained therapists. This facilitates the delivery of more intensive multi-disciplinary programmes where indicated whilst minimizing the number of therapists visiting clients' homes on a weekly basis.
- Where indicated, provide a through-care service for individuals discharged from hospital. The team liaises with referring agencies prior to discharge in order to provide a seamless transition whenever possible from hospital to home.
- Provision of advice, information and general support to the client and carers.
- Forging links with local resources and services to promote social and vocational integration e.g. Further Education, Into Work, Moving Intowork.
- Liaison with appropriate agencies and services, prior to rehabilitation, during rehabilitation and in preparation for discharge. This ensures clarity and efficient service delivery.
- Facilitation of clients' reintegration into the community by identifying the most appropriate ongoing resources / support.
- Input to various groups and fora, to contribute positively to the improvement and changing direction of physical disabilities and brain injury services in West Lothian and beyond.
- Provision of specialist advice, support and information to a range of community agencies who could assist with the rehabilitation process e.g. Home Care Workers, Local Day Centre Officers.

- Where identified that packages of care for individual clients are unnecessarily high, to re-assess and liaise with Social Work Departments in order to reduce packages of care to an appropriate level

## **THE BASE**

The Team are based in the Ability Centre in Carmondean, Livingston, which is a central base from which to provide the Service across West Lothian.

The team are co-located with the Ability Centre Support Service, Disability West Lothian, and the Housing Service. There is an ethos of partnership working for shared clients.