Specialist Rehabilitation Unit

Highfield Hospital

2018/2019

Description

The Specialist Rehabilitation Unit (SRU) in Highfield Hospital was developed as a 12-bed unit which opened in October 2018 within the approved centre. The SRU provides specialist inpatient rehabilitation for all Community Healthcare Organisations (CHOs) under a service level agreement with the HSE.

Referral process

Referrals from rehabilitation teams nationally are made to the HSE Steering Group for specialist rehabilitation units and inclusion/exclusion criteria are applied by the HSE steering group. Where inclusion criteria are met, the person is referred on to the rehabilitation team in Highfield Hospital.

The referral documentation is then reviewed by the consultant in rehabilitation, clinical nurse manager 3 (CNM 3) and members of the multi-disciplinary team (MDT). An assessment of the referred person is undertaken in that person's local hospital or community service by the consultant in rehabilitation, the CNM 3 and members of the MDT. This assessment also looks at the local rehabilitation services to support the person on their discharge from the SRU.

Specialist rehabilitation unit team

Consultant psychiatrist	1
Clinical Nurse Manager 3	1
Clinical Nurse Manager 2	1
Nursing staff on duty	2 day; 2 night
Peer support worker	1
Occupational therapist	1
Psychologist	1
Music therapist	1
Art therapist	1
Recovery support workers	2 day; 1 night
Social worker	1
Visiting GP	As required

Assessment

The assessment of each person includes:
Camberwell Assessment of Need, Health of Nation Outcome Scale, Clinical Global Impression Scale, Social Functioning Questionnaire, an evaluation of service user experience, and physical health assessment.

Therapy programme

The therapy programme includes:
Exercise (with a fitness trainer), healthy eating, art therapy, music therapy, cognitive behavioural therapy, cooking, computer skills, and a breakfast club.

Recreation activities include:
Movie nights and board games.

Peer support is an integral part of the rehabilitation programme and assists the service user in goal setting and community integration.

Discharge planning

Prior to admission, assessment is made as to whether the referring CHO has the capability to provide ongoing rehabilitation for the person following discharge from the SRU. A care coordinator professional from the referring CHO community team is appointed to liaise with the SRU MDT, the service user and their family throughout the service users stay in the SRU. It was not clear exactly how discharge of service users to appropriate rehabilitation services would be effected.

Conclusion

The SRU in Highfield had recently opened and was accepting referrals across all CHOs. This has resulted in the HSE providing “out of area” inpatient SRUs which is not in line with best practice.

The SRU was a well-designed unit with sufficient space. There was a wide range of therapies based on assessed need which included CBT and creative arts therapies, all of which were appropriate to providing a rehabilitation service. There was a formal referral and admission pathway from the referring CHO to the SRU. The staff impressed as being enthusiastic and knowledgeable.

There was no clear pathway agreed with the HSE for the discharge of each service user following their rehabilitation in the SRU. There appeared to be a difficulty in the HSE in committing to providing ongoing rehabilitation and accommodation following discharge, leading to the risk that service users would be discharged to more restrictive care without ongoing rehabilitation.