



Commission for Social Care Inspection
Key Inspection Report 2008

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Following on from an unannounced visit at Rehab Without Walls from a Lead CSCI Inspector in early December, we were delighted to hear that our quality rating has now improved from two star good, to three star excellent (to view this report, visit the CSCI web-site at www.csci.org.uk).

This without doubt reflects the hard work and commitment of our case managers and all the staff at Rehab Without Walls, as we constantly strive for an improved service for our clients, and aim to ensure that their needs are being met, whilst providing excellent value for money.

We anticipate that 2009 will be yet another exciting year, as we continue to develop and grow our service.

Watch this space!

rehabwithoutwalls

SUPPORT WORKER TRAINING PROGRAMME

In conjunction with the Open College Network, we have developed our own bespoke brain injury training programme for support workers working with clients who have sustained a brain injury.

This programme provides the equivalent of an NVQ2 accreditation, and aims to give the participants the knowledge and skills necessary for working as a support worker in the community, to enable them to provide the correct support to individuals who have suffered a brain injury.

For more information and availability on the training programme, please call Rehab Without Walls on 01908 560041.



rehabwithoutwalls
newsreview
WELCOME TO 2009

Rehab Without Walls has been providing high quality case management since 1995. In this time, we have also provided many Expert Reports in Care and Case Management, and in Neuropsychology.

We have continued to grow and develop, and have remained at the forefront of case management development, improving standards in practice and raising awareness of our particular client groups.

Everyone at Rehab Without Walls enjoys being part of a successful organization. Our reputation ensures that we attract the highest quality staff and maintain exceptional relationships with those who refer to us. The truest mark of our success however, is seen in the quality of our work with our clients and the quality of the support packages we manage.

In order to maintain the highest quality service, we have maintained our focus on what we do well, and continue to specialize in brain injury, spinal injury and catastrophic injury. We understand our clients' needs and know that, by using our dedicated skills and experience, we can provide them with exactly what they need "whatever it takes".

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IT'S NEVER TOO LATE!

THE BENEFIT OF LATE ONSET REHABILITATION AND CASE MANAGEMENT

Although academic research, experience and significant policy within the rehabilitation, medico-legal and case management field point towards the benefits of early rehabilitation and case management services; it is still the case that significant numbers of people with acquired brain injuries are not provided with rehabilitation until many years after their injury. In such cases, rehabilitation professionals may consider relatively modest outcomes to be probable and at worst, many consider working in situations of very late onset rehabilitation, to be relatively unproductive. In this brief article, I would like to challenge this view and suggest that in some situations, late onset rehabilitation may still produce dramatic and relatively rapid results.

This article is based upon my experiences in case managing three young adult males from widely differing backgrounds. For the purposes of the article, I will call them Mike, Pete and Bill. Mike was brain injured at the age of 10, case management started when he was 19.

Mike lived in an isolated rural community. Initial assessment indicated significant academic skills and ambitions, but very limited social skills, confidence and insight. Mike wanted to go to university; referral for case management was to assess the viability of this wish.

Pete was brain injured at the age of 12, case management started at age 23. Pete lived with his parents in a suburban estate. Initial assessment indicated problems with low mood, drug and alcohol misuse, self harming, low levels of general activity, and overall intellectual blunting. Pete had significant insight into some of his difficulties. Referral for case management was precipitated by Pete's parents' realisation that future problems were likely as they became older and less able to provide support.

Bill was brain injured at the age of 14; spending the subsequent years in a variety of residential and community rehabilitation resources. At age 28, his then Deputy had purchased a property for Bill. In addition Bill's behaviour in a local acquired brain injury community resource was becoming increasingly verbally and physically challenging. Referral for case management was to facilitate Bill's transition into his own accommodation. Bill's impairments include a significant hemiparesis, severe ataxia and significant memory problems.



He was, however, functioning at a relatively high intellectual level. Bill maintained that his challenging behaviours were largely "caused" by staff attitude.

At the onset of case management, it was apparent that all three clients were motivated to move their lives on, but that they were probably going to find the process difficult (all had spent many years doing very little). However, it also seemed that each client had the intellectual capacity, to "sign up" for rehabilitation. Each client was therefore offered the opportunity to agree to rehabilitation, with the proviso that the case manager would only cease his efforts if the client made it absolutely impossible to continue (perhaps this may be labelled the "terminator" approach to rehabilitation?). Each client and very importantly, family members agreed to this approach.

In Mike and Pete's case the next step was to obtain support workers whose personalities appeared likely to complement the client. Mike worked with one support worker, Bill with two; Mike's support worker was an older female, Bill's a slightly older male and a female. Previous experience of acquired brain injury work was not the priority, and all support workers were clearly intelligent and readily absorbed subsequent training.

In Mike and Pete's case, both sets of support workers were trained and supervised with a view to implementing very gradual, modest and "error free" (likely to produce a positive result but very unlikely to fail) changes. The emphasis was on underplaying enthusiasms and allowing the client to pull the rehabilitation process along.

In Bill's case, it was agreed that he would move to a local Neuro-Rehabilitation Facility as a transitional measure. Due to Bill's view that the controls applied by staff in his previous placement were inappropriately excessive and punishing, it was agreed that the new resource would adopt a much more laissez faire approach. We anticipated that Bill would greet his new freedoms and respond like an uncoiled spring! This did indeed take place.

All three client situations were risk assessed; Mike remained at risk from complex road traffic situations in unfamiliar settings, Pete remained at risk due to alcohol and cannabis consumption, and Bill remained at risk caused by drunken pranks!



In Mike's instance, careful research was undertaken as to which university would be the most positive and supportive (Mike undertook much of this research himself). Early links were established with appropriate staff and exploratory visits undertaken. Community support staff were identified, drawn from the student body. At this stage, the case manager considered that there was a low probability that Mike would cope at university.

In Pete's instance, accommodation was identified and a programme of independent living skills instigated. A college course was identified.

In Bill's instance, a 24 hour support package was commissioned and his accommodation adapted as appropriate.

At the time of writing, it is four years, two years, and 12 months respectively since rehabilitation and case management started for Mike, Pete and Bill. Mike is now successfully attending the second year of his university course, Pete is attending college, is cannabis free and has a girlfriend. Bill is pursuing a street art project, displays no challenging behaviours, undertakes many activities of daily living independently, and receives reduced support from (on average) 12 hours support worker input per day.

In all three instances, the case manager would like to claim the success for the dramatic improvements in the clients' lives, however (sadly!) this would be a (slight!!) misrepresentation. In all three instances, positive outcomes were as a result of:-

- **The client's unrealised potentials, abilities and insights.**
- **The "terminator" approach to rehabilitation.**
- **Careful matching of support worker staff to client.**
- **Family support.**
- **A very gradual approach.**

I am not suggesting that these simple principles, when applied in all instances, will yield marked results. However, I believe that many clients are prematurely "written off" due to the length of time that has elapsed since they were brain injured.

John Walker, Case Manager.

FOCUS on our Case Managers



Liz Munro
Case Manager

Liz qualified as an occupational therapist in 2002, and now works full time for Rehab Without Walls providing case management for both adults and children with brain injury in the North West.



Sarah Thompson
Case Manager

Sarah has now been with us over a year, and is based in Gloucestershire. Sarah qualified as an occupational therapist. As well as case managing clients at Rehab Without Walls, she also works at the Head Injury Therapy Unit in Bristol.



Linda Jooste
Case Manager

Linda started with us as a full time case manager in August 2008, leaving her previous role as senior social worker at Priory Highbank Neuro-rehab Unit. Linda is based in the Manchester area, and is currently case managing both adults and children with brain injury.



Tina Rogers
Case Manager

Tina is based in the West Midlands, and qualified as an occupational therapist. She has worked as a part-time case manager at Rehab Without Walls since September 2008.

For details of all our Case Manager's CVs, please visit our web-site at www.rehabwithoutwalls.co.uk



a holiday at the Calvert Trust

In August last year I sent one of my clients and his support worker to the Calvert Trust in Devon for an activity holiday.

This young man thoroughly enjoyed the activities on offer. He swam, went abseiling, sailed and rode horses, to name but a few of the things that he enjoyed. All the activities were new to him and he took full advantage of everything on offer.

My client told me that he was nervous, as it was all new to him, but he said that the staff there were all wonderful to him and they helped him to achieve so much.

In his words it was 'the best holiday I've ever had'. He also told me that 'I enjoyed it so much I didn't want to leave, I wanted to chain myself to the bed and stay there forever.' Not bad for someone who usually expresses his pleasure in any activity as 'it was alright I suppose'.

The support worker took photographs and they have been made into an album so that my client can remember the holiday and tell his family and friends about it. With the support worker's help my client was able to make new friends, some of whom he intends to keep in touch with.

Louise Woulfe, Case Manager.

A REHAB TEASER

- Q.** How many nurses does it take to change a lightbulb?
- A.** None, as the lightbulb will damn well change itself.

- Q.** How many OTs does it take to change a lightbulb?
- A.** Two, one to break the procedure down into its component parts and one to get the bulb out of its box.

- Q.** How many Social Workers does it take to change a lightbulb?
- A.** Three, one to check if the bulb meets the eligibility criteria, one to worry about it when it doesn't and one to do half a job.

- Q.** How many Neuropsychologists does it take to change lightbulb?
- A.** Several, as it's difficult to tell who has the capacity to change.

- Q.** How many SALTs does it take to change a lightbulb?
- A.** It's irrelevant, as SALTs don't get involved in that kind of thing.



One of the team has recently completed a piece of research as part of a MSc (Health Studies) the abstract is below – watch this space

The experience of the brain injured person and their family of having a case manager.

ABSTRACT

Although there has been considerable research on the wide ranging and long term problems experienced following severe head injury, there has been little research on the experience of rehabilitation from the perspective of the head injured person.

Case management has been recommended to facilitate access to services and to coordinate rehabilitation and care following brain injury. It is relatively new to the UK and there has been very little research on the efficacy of this emerging profession with head injury. Current knowledge does not reflect the perspective of the person in receipt of case management, or that of their family/carer.

This exploratory qualitative study used a phenomenological approach to increase understanding of the case management relationship and the experience of being case managed. Semi structured interviews were conducted with six people who had sustained a severe brain injury and their main carer(s).

Analysis of the data showed that case management was a collaborative partnership, in which the case manager played a role in linking the person back into everyday roles, routines and local activities, a process described as 'moving on' in the research. Although described as a practical/active process by the participants, the relationship with the case manager was a pivotal part of the experience, as was the perceived level of autonomy or control.

The ability of the carer to cope was enhanced by the support available from the case manager, while the main benefit to the person with brain injury was increased independence and community integration. The case manager performed a skilled balancing act to maximise independence, whilst keeping the individual safe.

The need for further research on optimal timing of intervention and the balance between autonomy and risk was identified.

Lynn Goodall, Case Manager.

For further information regarding any of our services please contact:

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