Community Neurological Rehabilitation Team
An information guide
Community Neurological Rehabilitation Team

Who are we?
The community neuro rehabilitation team provides rehabilitation for adults aged 18 and over, who have any neurological conditions or have acquired a brain injury. Patients may have a new diagnosis, a long term neurological condition, or a neuro degenerative condition. The team will provide rehabilitation in a variety of settings including a patient’s own home, clinic, residential care, work place or any other appropriate care setting.

The team provides appropriate assessment and treatment, maintenance, and advice to patients and their families living in the community. This aim is to enable people to function as independently as possible by improving or maintaining their physical, social and psychological wellbeing. The team also review the needs of people with chronic or deteriorating neurological conditions providing appropriate support to manage any changes in their condition.

Who is the service for?
• any adult with a neurological diagnosis
• aged 18 and over (or support for those transitioning from paediatric to adult services)
• any adult registered with a North Manchester GP who may be living in their own home, relative’s home, residential or nursing care
• adults who are medically stable and able to participate in a rehabilitation programme.
How to access the service

The Community Neuro Team accept both hospital and community referrals. The team carry out regular visits to Neurosurgery Units and Intermediate Neuro Rehabilitation Centres, and attend Multi-disciplinary Team (MDT) or discharge planning meetings to discuss rehabilitation needs of patients who will be discharged from inpatient services. At the point of discharge the ward will complete a referral into our team to continue your therapy at home.

The community referrals can come from any health or social care professional however, the team will ask for further medical information from your GP or consultant. If you have previously been known to the service you can contact us directly and self-refer for a review of your rehabilitation needs. Any healthcare professional can contact the team directly to discuss potential referrals.

Who does the team consist of?

- consultant
- neuro psychologist
- occupational therapists
- physiotherapists
- psychology assistant
- specialist nurse
- speech and language therapists
- therapy assistants.
What are the roles of each team member?

**Neuro Psychologist:** The psychologist within the team will aim to help individual patients and families recognise, understand and cope with many of the effects of a new or progressive neurological disability. This may include specific assessment of memory and thinking skills to discover strengths and any difficulties in order to provide strategies to overcome these problems. The psychologist can also support with adjustment difficulties which may impact on mood, or result in personality changes.

**Occupational Therapists:** The specific role of the Occupational Therapist includes the assessment and teaching of daily living skills, these may include washing and dressing, meal preparation, shopping or even working. Your therapist will assess your environment and provide therapy programmes, adaptations or aids which may increase your independence.

**Physiotherapists:** The physiotherapist will assess you physically and set exercise or balance programmes which are appropriate to work towards specific goals. Your physiotherapist may also set stretching programmes to maintain joint range and reduce risk of future complications such as pain or reduced movement. Physiotherapists will provide walking aids to maintain independence and reduce falls risks.

**Nursing:** There is a specialist nurse within the team who will give support with any medical concerns and medication needs. The nurse can monitor medical issues such as raised or low blood pressure (BP) concerns, diabetes management, pressure sore management, including assessment for pressure relieving equipment or to monitor skin integrity for those at risk of pressure ulcers and pain management. The nurse can support with health promotion advice. The role also includes liaising with consultants or GP's for medical reviews and acting as advocates at clinical appointments.
Speech and Language Therapists: The Speech and Language therapist will assess and plan treatments for any patients that have communication problems. These may include difficulties with understanding the spoken or written word and/or expressing themselves using speech, gesture, and/or the written word.

In addition they will assess, advise and treat patients who have difficulty with swallowing and feeding in order to help prevent further health complications.

Therapy Assistants: Our therapy assistants work closely with all therapists including occupational therapists, physiotherapists, speech and language therapists and nursing staff to follow specific treatment programmes set in order to achieve identified goals.

What will happen while I am seen by the team?

You will be contacted by a member of the team who will carry out a triage call. The purpose of this call to see how you are managing with your medication, personal care needs and mobility or if you've had any falls in order to determine the best therapist to assess you.

As part of the initial assessment we will

- take personal details including relevant medical history, medication lists, and discuss details about the problems you are experiencing
- complete a neurological assessment of your needs
- discuss realistic goals to work towards and complete a support plan collaboratively with the patient or next of kin
- discuss which professionals are likely to be involved in your care
- in some cases referrals onto other services may be appropriate.
What treatment may I receive?

Depending on the problems identified, follow-up treatment sessions will be carried out by the relevant team members. Intervention may include physical therapy, cognitive rehabilitation, return to work support, psychological adjustment, communication therapy, swallow advice, and medical management. We may also offer support and training to your family or carers regarding your specific needs.

Patients are usually given treatment programmes that they are encouraged to complete between visits if able, this aims to speed recovery. Relatives are also encouraged to participate in the rehabilitation process.

What is the discharge process?

Patients will be discharged from the service when they have achieved their goals, or if there are no significant improvements following treatment. The service will discharge patients within 6 months of referral unless there is a specific ongoing clinical need. At the point of discharge we will write a letter to your GP and any other relevant professionals so they are aware of the input you have received.

Please be aware that if patients fail to attend appointments or are not carrying out recommended therapy intervention they may be discharged and will require a new referral to access the service in the future.

Please note that, to improve the quality of your care and with your consent, information is shared securely between health and care organisations involved in your care. Please let a member of staff know if you do not wish your information to be shared in this way. Please see our website pages for further details: www.pat.nhs.uk.
Contact details

If you require any further information on the Community Neuro Rehabilitation Service please contact:

Community Neuro Rehabilitation Team, Charlestown Health Centre, Charlestown Road, Manchester, M9 7ED, Tel: 0161 741 2007/2008 Fax: 0161 741 2037.
If English is not your first language and you need help, please contact the Ethnic Health Team on 0161 627 8770.

For general enquiries please contact the Patient Advice and Liaison Service (PALS) on 0161 604 5897.

For enquiries regarding clinic appointments, clinical care and treatment please contact 0161 624 0420 and the Switchboard Operator will put you through to the correct department / service.

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