Scope of Service 2024

What is ABI Rehabilitation?

ABI Rehabilitation is a leading provider of comprehensive, specialised rehabilitation services for people with an acquired brain injury (ABI).

ABI has services throughout Aotearoa New Zealand including:

- Intensive inpatient rehabilitation and day rehabilitation in Auckland, Hamilton and Wellington
- Residential rehabilitation and disability support services in community-based homes across West Auckland and Hamilton
- In-home and clinic-based community rehabilitation, specialist assessments and equipment provision
- Paediatric assessment and rehabilitation in community settings and schools.

About ABI Rehabilitation

ABI Rehabilitation was established in 1996, and over the years has earned the reputation of a first class provider of traumatic brain injury and stroke rehabilitation, supporting thousands of kiritaki (clients) and whānau on their journey to recovery, with many returning to their homes and communities to rebuild their lives. This work has been supported by an outstanding team of over 400 kaimahi (staff) who consistently deliver compassionate rehabilitation across a continuum of care. Our strength is in our people: the people we serve, the whānau we work alongside, and the kaimahi (staff) who dedicate their skills and experience to making a real and lifelong change in the rehabilitation journey of many.

ABI Rehabilitation’s mission

The mission of ABI Rehabilitation is to work in partnership with the kiritaki (clients) and whānau to restore wellness to the maximum extent possible whilst setting standards of excellence in neuro-rehabilitation.

ABI Rehabilitation's values

ABI Rehabilitation makes connections and creates opportunities enabling kiritaki (clients) to achieve health and wellbeing. Together we make a positive difference recognising the value of western science alongside mātauranga Māori expertise.

- **Pono and tika – Honest and right**
  We act with integrity, take pride in our mahi and are accountable for our actions. We provide the right services at the right time to support client-centred rehabilitation
- **Pūkenga – Expertise and knowledge**
  We commit to best practice in the science of rehabilitation, partnerships with mātauranga Māori expertise and to value the skills and knowledge of our kiritaki (clients) and whānau. We are passionate about learning and sharing knowledge
- **Mana ōrite – Work together equally**
  As partners, we maintain the mana of all by being inclusive, valuing others world views and culture
- **Manaaki – Aroha, respect and support**
  We value the mana of kiritaki (clients),whānau, kaimahi (staff) and stakeholders and engage with respect, kindness, aroha and support
- **Wairua – Spirituality**
  We value holistic wellbeing and respect individual’s spirituality and their spiritual connections with tangata (people), tīpuna (ancestors) and the taiao (environment).

ABI Rehabilitation programmes include:

- Emerging Consciousness Programme (ECP)*
- Medical – nursing rehabilitation
- Community reintegration
- Neurobehavioural programme
- Day rehabilitation
- Stroke rehabilitation
- Pastoral care
- Whānau education
- Assistive technology
- Concussion rehabilitation
- Return to work vocational programmes
- Medical assessments
- Community rehabilitation
- Recreation therapy and adaptive rehab programmes including hydrotherapy, art, music, horticulture and outdoor experiences
- Health and wellness
- Behaviour support programmes
- Paediatric assessment and rehabilitation
- Pet therapy
- Transition support for return to home
- Specialised wheelchair seating and positioning
- Upper extremity rehabilitation
- Spasticity management
- Vestibular and balance
- Support needs assessments

**This programme is currently available in Auckland and Wellington services.*

Introduction to intensive inpatient rehabilitation

ABI has three inpatient rehabilitation services in Auckland, Wellington and most recently, Hamilton. This intensive rehabilitation provides inpatient services for people aged 16 years and over to enable kiritaki (clients) to achieve the highest level of function and quality of life possible (with whānau and funder approval, exceptions may be made for younger people if they are more suited to an adult service).

Most people are referred to the inpatient intensive rehabilitation service by a public hospital following a moderate to severe traumatic brain injury (TBI).

Referrals are also accepted for anyone living in the community who may benefit from inpatient or day rehabilitation and are living in the community with a brain injury.

We aim to make the phases of transition to and from ABI Rehabilitation inpatient service as seamless as possible through effective handover and planning.

Auckland inpatient service

In Auckland, the ABI Rehabilitation intensive programme is provided in a 36 bed rehabilitation campus. While onsite, kiritaki (clients) live in one of eight comfortable houses. Each house has one to eight bedrooms and has its own ‘character’ suitable for the needs of those residing in them. This includes a low stimulation environment for kiritaki (clients) with a low level of consciousness and a safe treatment environment for those with significant behavioural symptoms. With the exception of the one bedroom units, the houses are fully wheelchair accessible and have ‘to-the-door’ access for ambulances and transport vans.

Additionally, the campus has communal areas for outdoor recreation and lots of green space including a sculpture garden. Larger central buildings contain the administration offices and rehabilitation facilities, including a gym, kitchen area and training rooms.

Wellington inpatient service

The Wellington intensive inpatient rehabilitation programme is provided at a 25 bed rehabilitation centre in Porirua.

The indoor and outdoor areas are wheelchair accessible, and rooms are located around a central courtyard. There is a communal lounge and dining room as well as areas for kiritaki (clients) and whānau to socialise and engage in hobbies. With on-site laundry and kitchen facilities, kiritaki (clients) can perform day-to-day domestic activities as soon as they feel able to. The centre also features clinical spaces, including a gym and activities room. In addition there is separate self-contained unit located onsite to prepare for transitions from the inpatient rehabilitation setting to home.

Hamilton inpatient service

ABI Rehabilitation began developing an intensive inpatient rehabilitation service in Hamilton early in 2024 and admitted the first kiritaki (client) to this service in June 2024. This service is based within a larger residential facility offering a mix of intensive and residential beds. The site has 22 beds. There is a “villa” with single rooms and shared bathroom facilities, and a number of one and two bedroom units, all of which are wheelchair accessible. Central to the facility is a large landscaped courtyard with accessible spaces for kiritaki (clients) and whānau to enjoy. Other shared spaces include a recreation room and dining area. Therapeutic spaces include a gym, treatment room and a therapy kitchen.

ABI intensive inpatient kaimahi (workforce)

Tony Young

General Manager

The team consists of the following disciplines who work together to deliver an integrated approach to rehabilitation:

- Rehabilitation Nursing
- Rehabilitation Assistants
- Rehabilitation Medicine
- Physiotherapy
- Occupational Therapy
- Speech Language Therapy
- Neuro/Clinical/Behavioural Psychology
- Social Work
- Keyworkers
- Kaiārahi Kaupapa Māori (Māori cultural support)
- Neuropsychiatry
- Specialties e.g. podiatry, dieticians
- Other rehabilitation services e.g. massage and pet therapy.

Depending on the rehabilitation service required, these can be delivered 24/7, on-call, weekdays and as required by referral.

Rehabilitation Programme

Through intensive inpatient rehabilitation, we help kiritaki (clients) gain as much independence as possible as they look to rebuild their lives. Kiritaki (clients) and whānau may engage in one or parts of several rehabilitation programmes depending on their needs. The rehabilitation team is guided by a rehabilitation physician and, together with kiritaki (clients) and whānau, they develop individual treatment plans based on each kiritaki's (client's) recovery goals. Kaimahi (staff) understand that after a brain injury, people often struggle to navigate a new way of life. Our services are designed to meet the physical, cognitive, medical and emotional needs of each person as they work towards independently accomplishing everyday activities such as working, driving and parenting.

Programmes include:

The Emerging Consciousness Programme supports kiritaki (client's) in a minimally conscious state, who are often not ready to begin an active rehabilitation programme upon entry to the service. It focuses on medical and nursing care to prevent complications, sensory stimulation, early cognitive therapy and whānau education and support. Close monitoring and assessment enables ABI Rehabilitation to alter a kiritaki's (client's) programme to aid their recovery.

The Medical and Nursing Rehabilitation Programme focuses on early interventions to improve wellbeing and minimise medical complications. It includes supporting, coaching and assisting the kiritaki (client) and whānau to adapt and self-manage.

The aim of the Neurobehavioural Rehabilitation Programme is to give kiritaki (clients) the tools they need to take control of their own behaviours.

The Community Re-Integration Programme prepares kiritaki (clients) to return home and participate in the community. It also includes providing education and support to whānau specific to community re-entry and preparing for discharge.

If kiritaki (clients) can reside at home and live locally, the Day Rehabilitation Programme may be an option (access to therapy is the same as inpatient services).

The Stroke Rehabilitation Programme helps those who have experienced a stroke to relearn skills. It also includes education and training for whānau so that they can identify risks that lead to complications, including another stroke.

Programme Structure

The inpatient rehabilitation programme is structured around a working day to ensure a balanced approach to life while a kiritaki (client) is residing at ABI Rehabilitation.

- The ‘intensive therapy work hours’ between 07:00 and 15:30 are dedicated to intensive rehabilitation around a structured timetable of medical, therapy, nursing and self-directed rehabilitation activities. These are built around the goals that have been agreed with each kiritaki (client) and their whānau.
- The recreation and social part of the day is from 15:30-20:30. This is less structured but an equally important part of the programme to ensure social and whānau relationships are maintained and that there are opportunities to pursue areas of personal interest.
- The hours between 20:30 and 08:30 are dedicated rest hours. Fatigue management and quality sleep plays an important role in maintaining engagement in the rehabilitation programme. A time of rest gives each kiritaki (client) the best opportunity for progress.

Secondary Complications

ABI Rehabilitation understands that people requiring intensive brain injury rehabilitation often present with one or more significant secondary complications such as spinal cord injury, limb loss, multiple fractures, internal injuries or cardiovascular complications.

As part of the preadmission process, the preadmission team (alongside our rehabilitation medical specialists) determine medical stability and work with all those involved to make recommendations ahead of entry to an ABI Rehabilitation centre. In some cases, such as with spinal cord injuries, the treatment pathway could be to first attend the spinal cord rehabilitation unit and then to enter the brain injury rehabilitation unit. In such cases, brain injury education and support via in reach would be possible. Likewise, if the treatment pathway is to the brain injury unit first, other specialist services can be accessed via in-reach arrangements with those services. The etiology, level or completeness of the spinal cord damage will factor into the clinical decision making but not be the determining factor. Collective decision making between the providers and funders occurs to determine the best rehabilitation pathway for the kiritaki (client).

Funding and referrals

ABI Rehabilitation accepts referrals from private individuals, ACC, hospitals, the Ministry of Health and a range of medical insurers. Rehabilitation services generally funded include medical, nursing, allied health therapies, accommodation, laundry and food. Personal items such as toiletries can be provided, however we encourage you to bring your own. For kiritaki (clients) that receive funding, there may be some items that are not included or have a co- payment such as certain medications or dentistry. Any items that are not funded are discussed with the kiritaki (client) and their whānau.

Cultural needs

Kiritaki (clients) and their whānau are at the centre of rehabilitation planning, implementation and evaluation. Te Hekenga-ā-ora (Māori Development Plan) guides and supports kaimahi (staff) in providing culturally appropriate rehabilitation services. We ensure that everyone entering an ABI Rehabilitation centre experiences manaakitanga (respect) safety, warmth and security – feelings that are experienced when a korowai (feathered cloak) is worn.

Residential rehabilitation

Residential rehabilitation services in Auckland offer kiritaki (clients) comprehensive 24 hour residential support. The service enables kiritaki (clients) to attain the best quality of life through person-centred activity programmes, including slow-stream rehabilitation and recreation within a community setting. The kiritaki (client), whānau, the funder and ABI Rehabilitation kaimahi (staff) meet regularly to review each kiritaki's (client's) rehabilitation plan, particularly if it is likely that they may be able to return home after a period of residential rehabilitation.

Individual rehabilitation goals form part of the plan. These goals focus on increasing community participation and improving functional ability e.g. improving communication, mobility, or behaviour within community settings. The plans and support may also involve lifeskills and leisure activities such as community sports and volunteer or supported employment.

Outings in the community are encouraged and integrating into each kiritaki's weekly schedule such as trips to libraries, community centres, Sailability Auckland, Riding for the Disabled, churches, parks, gyms, cafés etc. Occasional group activities also include trips to the zoo, rugby games, mini golf courses, and museums.

Whānau are encouraged to participate in activities and kiritaki (client) visits to home are facilitated. When appropriate, kiritaki (clients) may visit each other for social morning teas, BBQs and to play pool, basketball, bingo and other leisure activities.

Access to the residential service

The programme is available to anyone over the age of 16. Referrals are typically from ACC or the Ministry of Health for kiritaki (clients) with a brain injury or other neurological impairments who cannot live independently in the community.

Should the individual have spinal cord damage in addition to their acquired brain injury there would need to be a preadmission risk assessment to ensure their care and rehabilitation needs could be met. The etiology, level or completeness of the spinal cord damage will factor into the clinical decision making but not be the determining factor. Collective decision making between the providers, funders, kiritaki (client) and whānau will occur to determine if residential services will meet their needs.

On receipt of a referral from the funder, a pre-admission assessment is conducted. The service supports kiritaki (clients) who are in a minimally conscious state and require full assistance with all day-to-day activities, through to those who may be discharged and regain independence.

Residential service setting

There are five houses with a total of 35 beds situated across the west Auckland community. The houses have been modified and equipped as appropriate. For example, there are wheelchair accessible houses and a house in a more secure environment for clients who are cognitively impaired.

Kiritaki (clients) are allocated a house according to their specific medical and rehabilitation needs. Everyone is encouraged to personalise their own room, and all houses feature a lounge, dining area and kitchen. Generally, all meals are prepared by kaimahi (staff) in the kitchens onsite. Each kiritaki's (client's) dietary and cultural food requirements are met as they have the opportunity to get involved in meal planning and preparation.

Residential discharge process

Where appropriate, discharge/transition from residential services to more independent living is encouraged and supported. In order to provide the best support to a kiritaki (client) and their whānau, ACC case managers and/or the Needs Assessment and Service Coordination (NASC) service are involved in the discharge process, as are the rehabilitation team and GP, and others as required.

ABI residential kaimahi (workforce)

Andria Bayer

Northern Regional Manager – ABI Residential Service

The team consists of the following disciplines who work together to deliver an integrated approach to residential rehabilitation:

- Rehabilitation Nurses
- Rehabilitation Assistants
- Occupational Therapy
- Physiotherapy
- Speech and Language Therapy available
- Neuropsychiatrist
- Rehabilitation Physician
- Neuropsychologist
- Dietician

Depending on the rehabilitation service required, these can be delivered 24/7, on-call, weekdays and as required by referral.

Community service rehabilitation

ABI Rehabilitation provides specialist services for both adults and children through its community services, which include assessments, treatment and therapy programmes. Services are delivered by a range of high skilled and compassionate professionals who cover a wide range of injuries from mild to severe traumatic and hypoxic brain injuries through to fractures. The frequency of these services is dependent on the contract under which the service being received and kiritaki (client) need.

With treatment-based services, rehabilitation is planned following an assessment of each kiritaki (client's) rehabilitation needs. Kiritaki (clients) often need to receive services from more than one of the ABI team members e.g. a physio and an occupational therapist. The interdisciplinary team works with each kiritaki (client) under the guidance of a keyworker to assist with the coordination of rehabilitation. This ensures each kiritaki (client) receives a seamless specialist service with great outcomes.

The interdisciplinary team visits most of their clients in the community as the focus of the community service is to support kiritaki (clients) to return to independence in their homes, schools, workplaces and communities.

ABI community kaimahi (workforce)

Dr. Richard Seemann

Specialist in Rehabilitation Medicine (Community Services)

The team consists of the following disciplines who work together to deliver an integrated approach to rehabilitation:

- Rehabilitation Medicine Physician
- Physiotherapy
- Occupational Therapy
- Speech Language Therapy
- Neuro/Clinical/Behavioural Psychology
- Social Work
- Rehabilitation nurses
- Rehabilitation coaches
- Dietician

Community Service Funding

The majority of the contracts held are fully funded under ACC. However, there are non-ACC services available.

Some of these services are regional, while others are national.

National contracts
Support Needs Assessments
Behavioural Support Services
Education-based Rehabilitation Assessments
Retrospective Personal Support Assessments
Spasticity Management Services

AUCKLAND	NORTHLAND	WELLINGTON
Concussion Services	Concussion Services	Concussion Services
Training for Independence Services	Training for Independence Services	Training for Independence Services
Medical Specialist Assessments	Medical Specialist Assessments	Medical Specialist Assessments
Neuropsychological Assessments	Neuropsychological Assessments	Neuropsychological Assessments
Psychological Services	Psychological Services	Psychological Services
Vocational Services	Vocational Services	Vocational Services
Social Rehabilitation Needs Assessments		Social Rehabilitation Needs Assessments
Initial Occupational Assessments		
Vocational Medical Assessments		
Specialised Wheelchair and Seating Assessments		

Community Service setting

Auckland community services is based out of three office sites in Central, South and West Auckland. The clinic buildings in Epsom, Botany and NorthWest Shopping Centre are accessible for all people, close to public transport and have plenty of free parking.

Our team in Northland work remotely and from our partner organisation's clinic space to provide clinic-based sessions or visits to kiritaki (client's) homes, school or work.

The Wellington community service is based in at the intensive inpatient service in Porirua which allows for seamless transitions for our kiritaki (clients) who move from an inpatient to community setting.

The interdisciplinary team visits most of their kiritaki (clients) in the community as the focus of the community service is to support a return to independence in their homes, schools, workplaces and communities. Outpatient clinics are also held at the main facilities. These are managed via a booking/appointments system. Support people are welcome to attend any appointments.

Access to and discharge from community rehabilitation

Referrals can come via ACC, GPs or kiritaki (clients) themselves. However, prior to an assessment, funding approval is required from ACC under one (or more) of the contracts named in the table above.

Being discharged from community rehabilitation means a kiritaki (client) has reached a pre-determined level of independence with either work, home, school and/or community activities.

There are some ACC funded services that are a one-off assessment, so kiritaki (clients) may be discharged after one episode or intervention (e.g. support needs assessments, neuropsychological screens, social rehabilitation assessments).

Paediatric community rehabilitation

A specialty within our community rehabilitation services is paediatric community rehabilitation for children aged between birth and school leaving age.

ABI Rehabilitation community services have an allied health team who are experienced and specialised in working with children with developmental concerns, disabilities and acquired injuries. We assist children and their whānau from birth through to leaving school, using a whānau-centred model of care, that recognises the family as the expert in your child's care and our team as expert partners supporting your goals and aspirations. Our professional team includes occupational therapists, physiotherapists, speech-language therapists, dieticians, social workers, nurses and psychologists. We accept referrals from ACC and other funding agencies and also welcome enquiries for privately funded services.

We provide assessments and treatment for a variety of conditions including:

- Developmental delay
- Cerebral palsy
- Concussion
- Brain injury
- Dyspraxia
- Spinal cord injuries
- Spasticity
- Gait problems
- Speech delay
- Fine motor skill development
- Managing sensory or emotional/behavioural needs

An ABI community kaimahi (staff member) engaging in play based therapy with a young child.

Delivering rehabilitation through telehealth

Prior to the global pandemic, ABI provided occasional telehealth services to kiritaki (clients) and whānau as required by some who it was deemed more appropriate for several reasons.

Throughout the pandemic, it was a valuable rehabilitation resource to have for those requiring support across all services. Recognising the value of telehealth as a service that meets the needs of some kiritaki and whānau (particularly those in more rural areas), ABI developed a suite of resources and continues to support some kiritaki (clients) and whānau with this type of virtual rehabilitation.
Resources can be viewed here.