Integrated Healthcare Conference

Disability Services

Wicklow Hall 2, Convention Centre Dublin
4 September 2025. 14:25 – 15:40

Rialtas na hÉireann
Government of Ireland

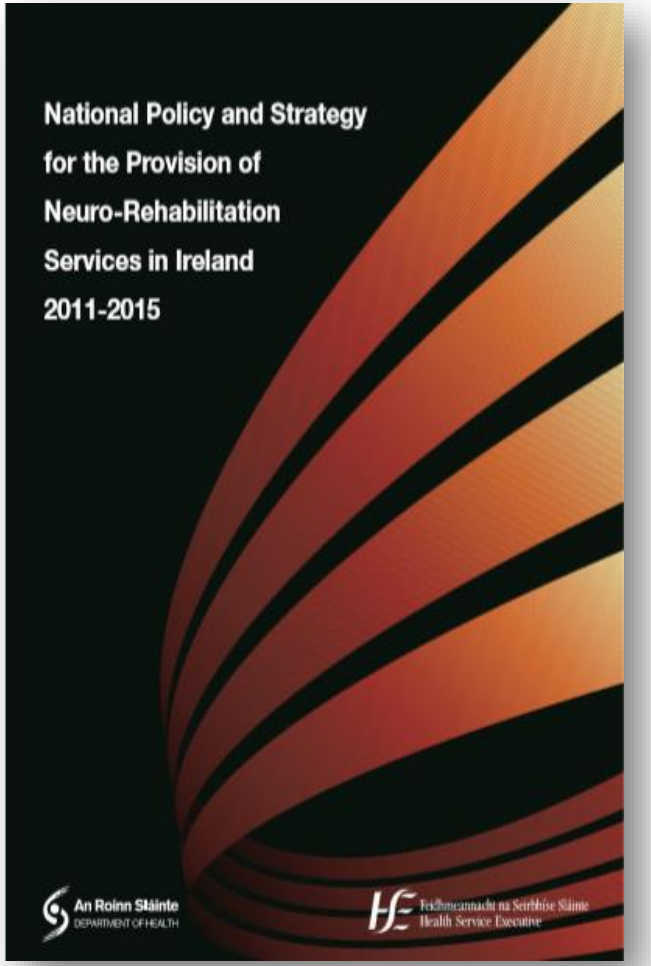
SPoA and the National Neuro-Rehabilitation Strategy

Aoife O'Donoghue
AND Disability Services

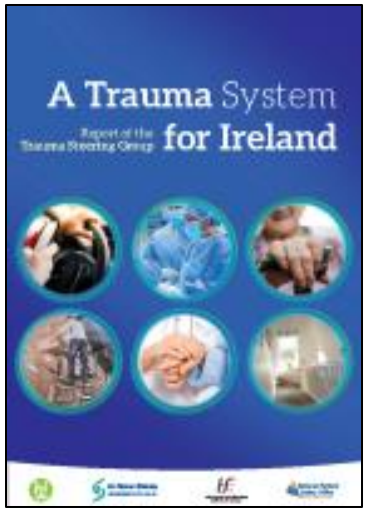
National Neuro-Rehabilitation Strategy: An Overview of Care

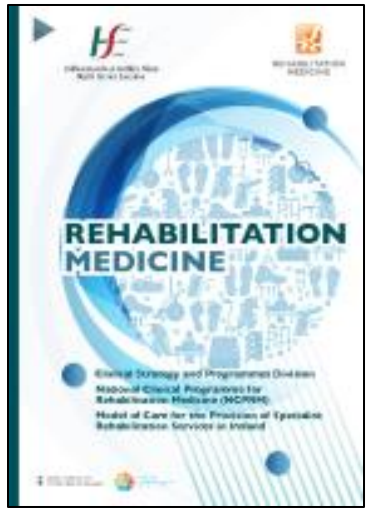
Ciara Lynch
Programme Manager, National Neuro-Rehabilitation Strategy

The Strategy

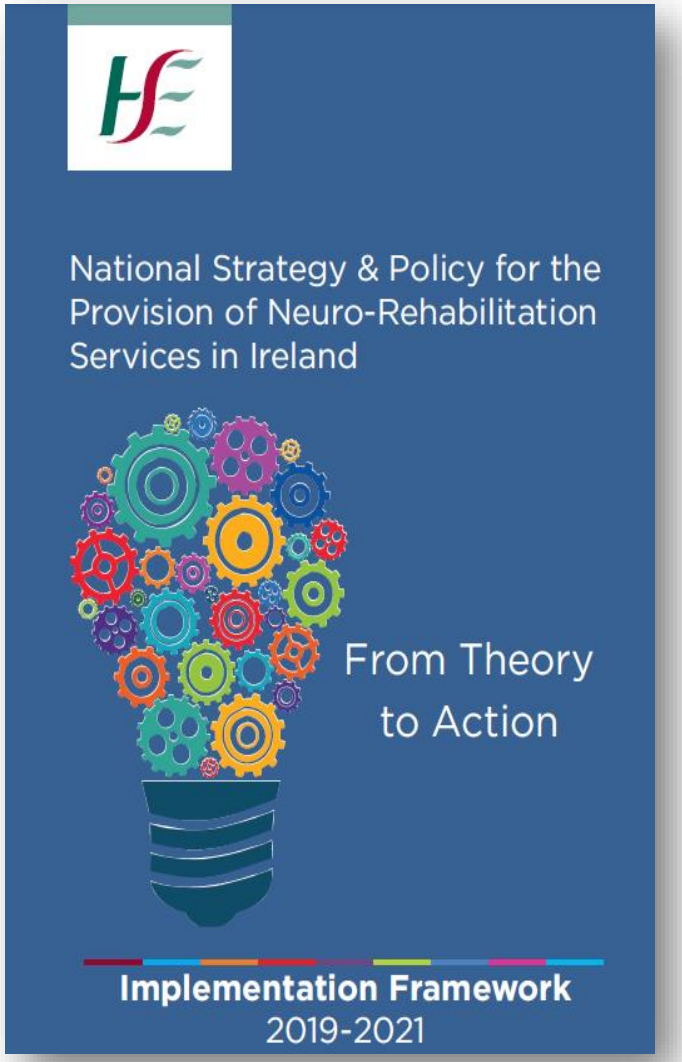


An action within

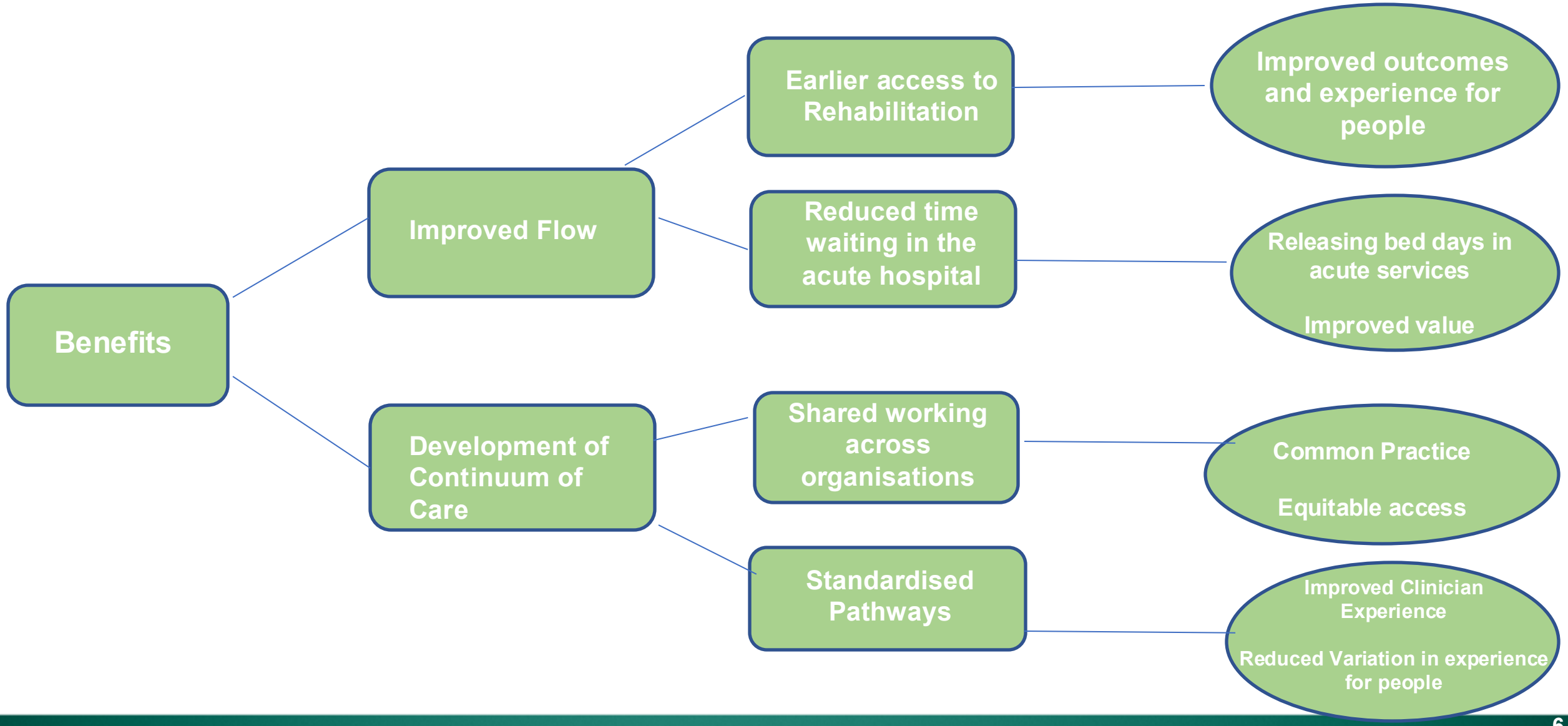




The Implementation Framework



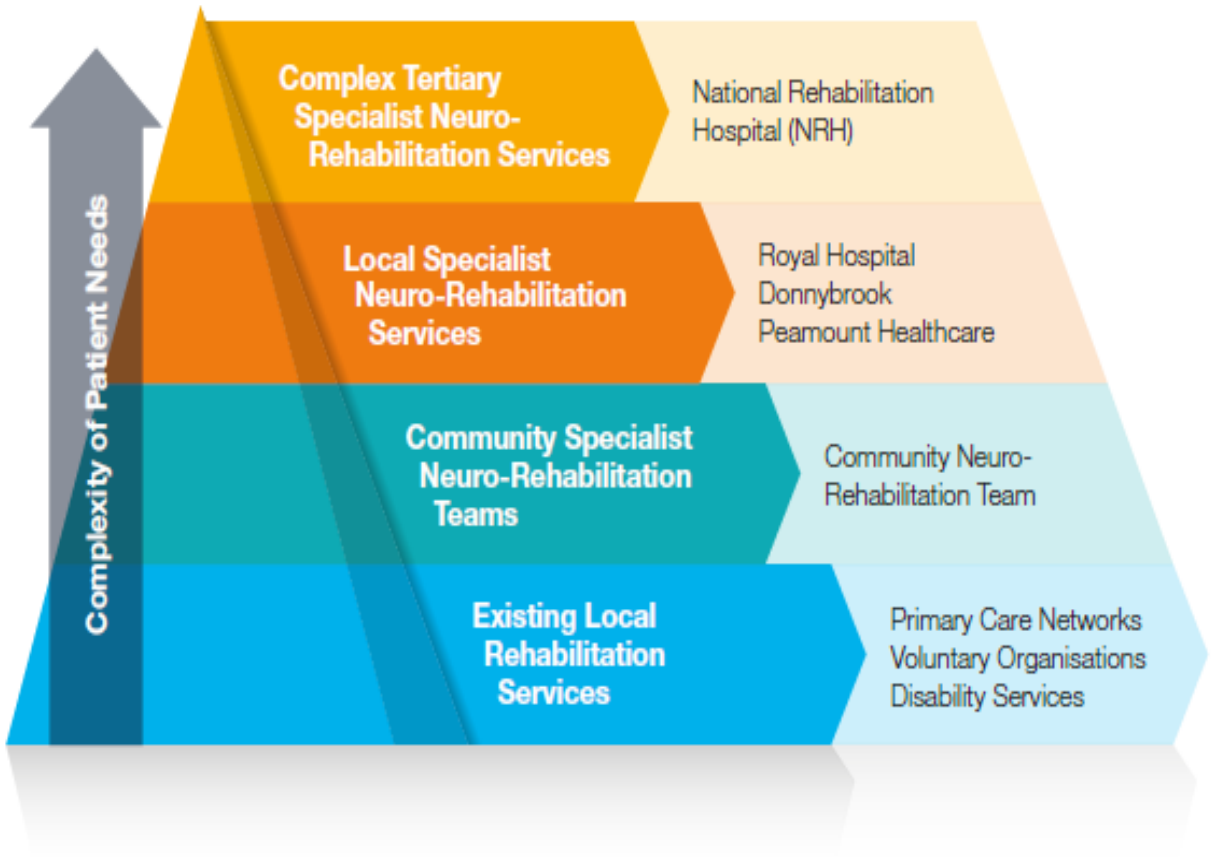
Benefits of the MCRN Model



Managed Clinical Rehabilitation Network (MCRN) Model

The new model sees the introduction of a mutli-tiered system , with access to services based on clinically assessed need.

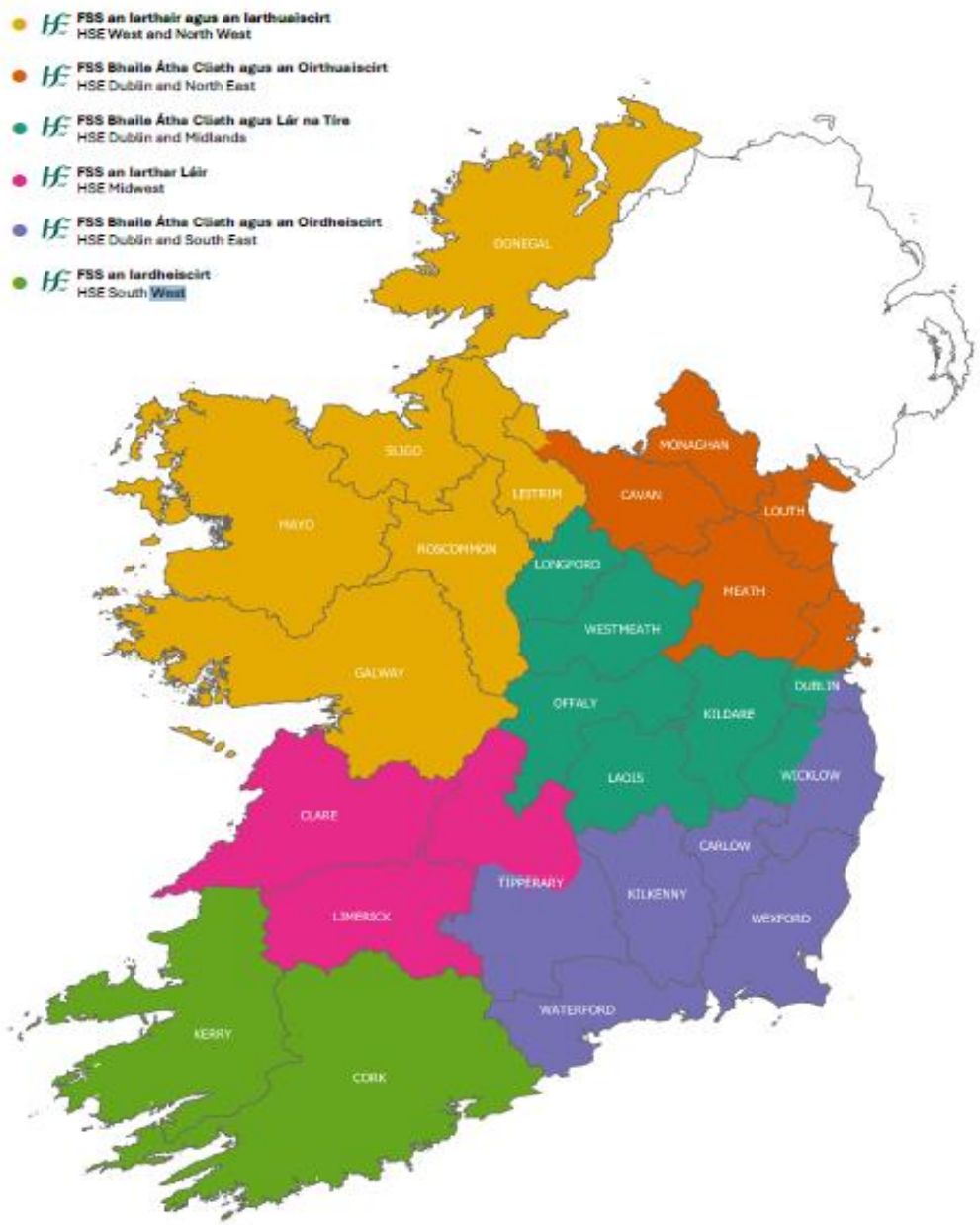
- Shared assessment protocols
- Shared Referral Protocols
- Shared waiting List Management Protocols
- Shared Discharge Planning Protocols



National Picture

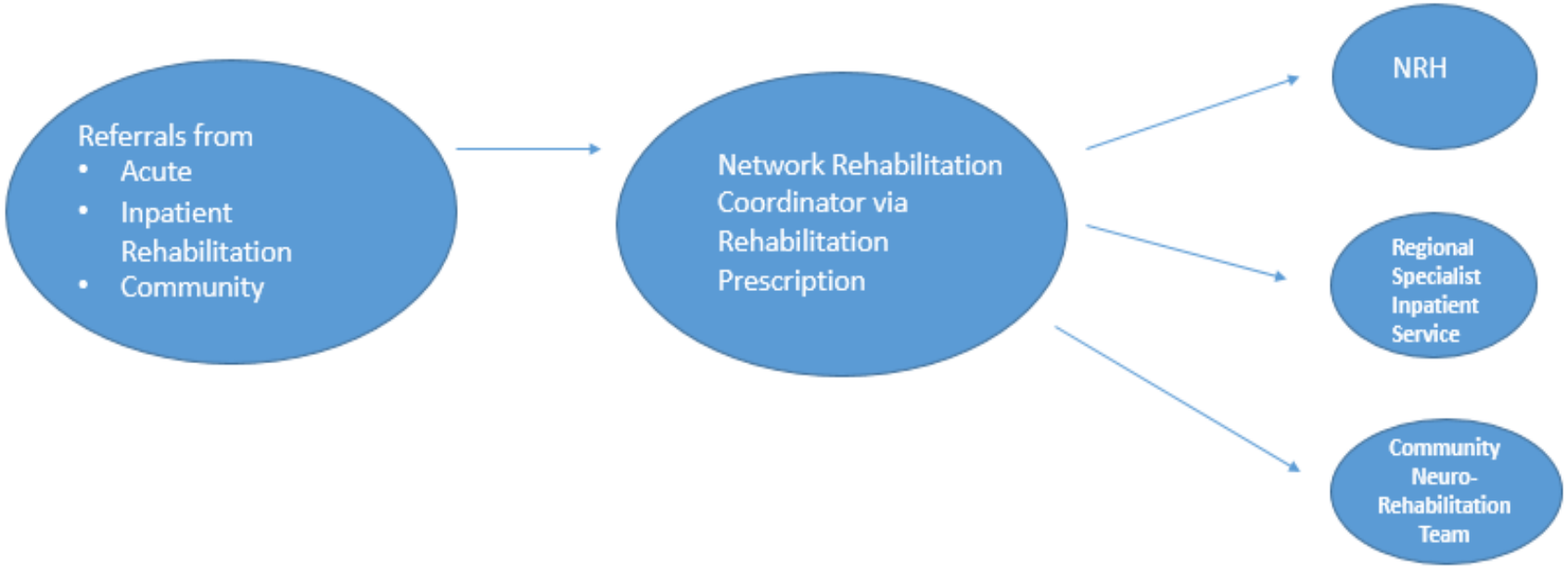
6 MCRNs Nationally, one per Region:

- Complex Specialist Tertiary Neuro-Rehabilitation Services- National Rehabilitation Hospital
- 6 x Regional Specialist In-patient services (Level 2)
- 6 x Community Neuro-Rehabilitation Teams (CNRTs)



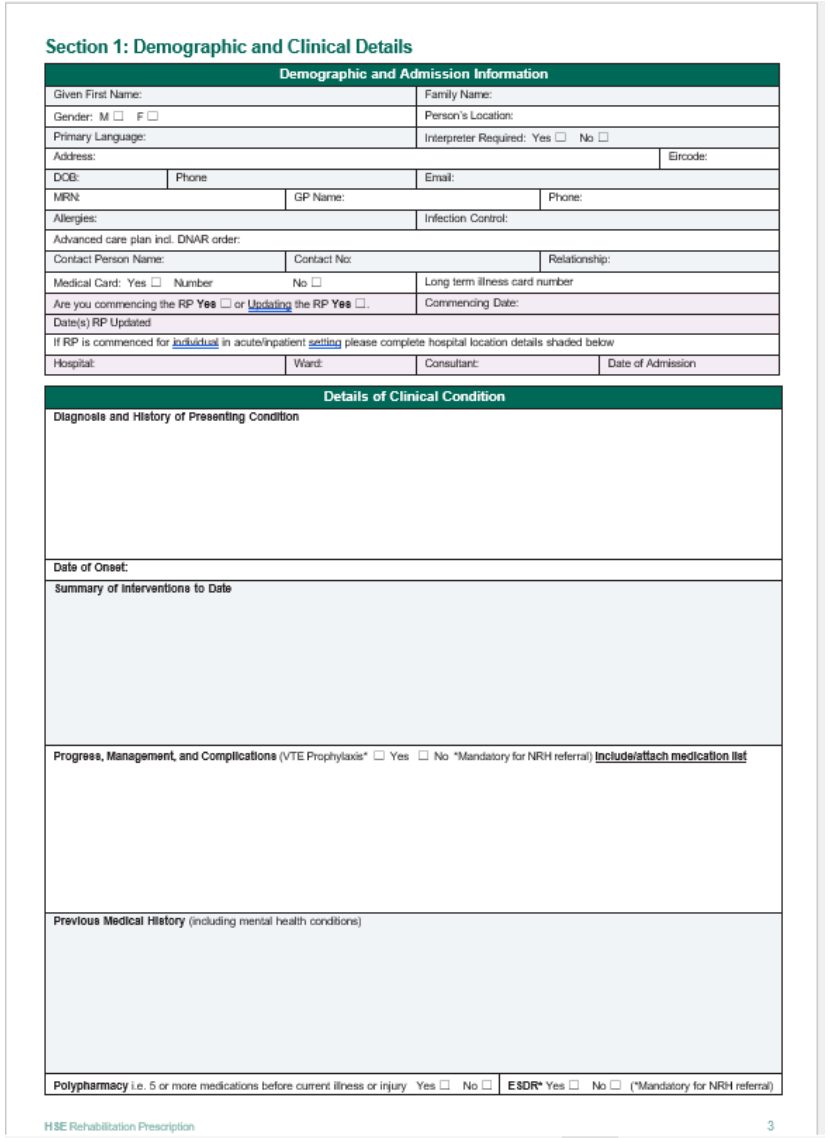
MCRN Network Rehabilitation Co-ordinator

- **Pivotal Role**
- **Single point of entry for all referrals**



Rehabilitation Prescription

- National standard approach for assessing people's rehabilitation needs.
- Used to develop management plan that addresses a person's goals.
- Acts as the referral form for MCRN Neuro-Rehabilitation services.
- Currently in use through Trauma, NRH Adult services.
- Neuro-Rehabilitation services in the demonstrator sites.
- Live document that follows the person and the individual is informed that they are referred to a network of services.
- RP revised, regional webinars and live in September.



Section 1: Demographic and Clinical Details

Demographic and Admission Information			
Given First Name:		Family Name:	
Gender: M ☐ F ☐		Person's Location:	
Primary Language:		Interpreter Required: Yes ☐ No ☐	
Address:			Eircode:
DOB:	Phone	Email:	
MRN:	GP Name:		Phone:
Allergies:		Infection Control:	
Advanced care plan incl. DNAR order:			
Contact Person Name:	Contact No:		Relationship:
Medical Card: Yes ☐ Number	No ☐	Long term illness card number	
Are you commencing the RP **Yes** ☐ or Updating the RP **Yes** ☐.		Commencing Date:	
Date(s) RP Updated			
If RP is commenced for individual in acute/inpatient setting please complete hospital location details shaded below			
Hospital:	Ward:	Consultant:	Date of Admission

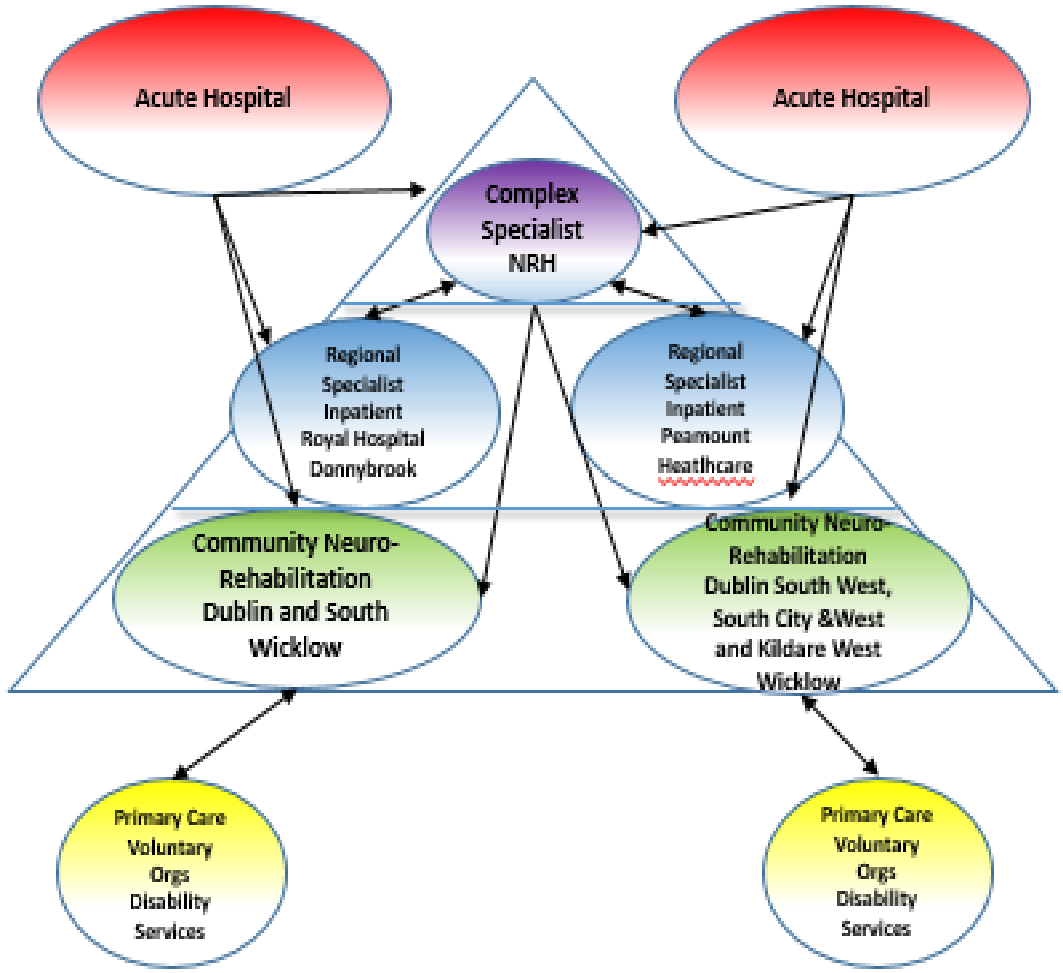
Details of Clinical Condition
Diagnosis and History of Presenting Condition
Date of Onset:
Summary of Interventions to Date
Progress, Management, and Complications (VTE Prophylaxis* ☐ Yes ☐ No *Mandatory for NRH referral) Include/attach medication list
Previous Medical History (including mental health conditions)
Polypharmacy i.e. 5 or more medications before current illness or injury Yes ☐ No ☐ **ESDR*** Yes ☐ No ☐ (*Mandatory for NRH referral)

HSE Rehabilitation Prescription 3

Complete networks in Dublin and South East and Dublin and Midlands

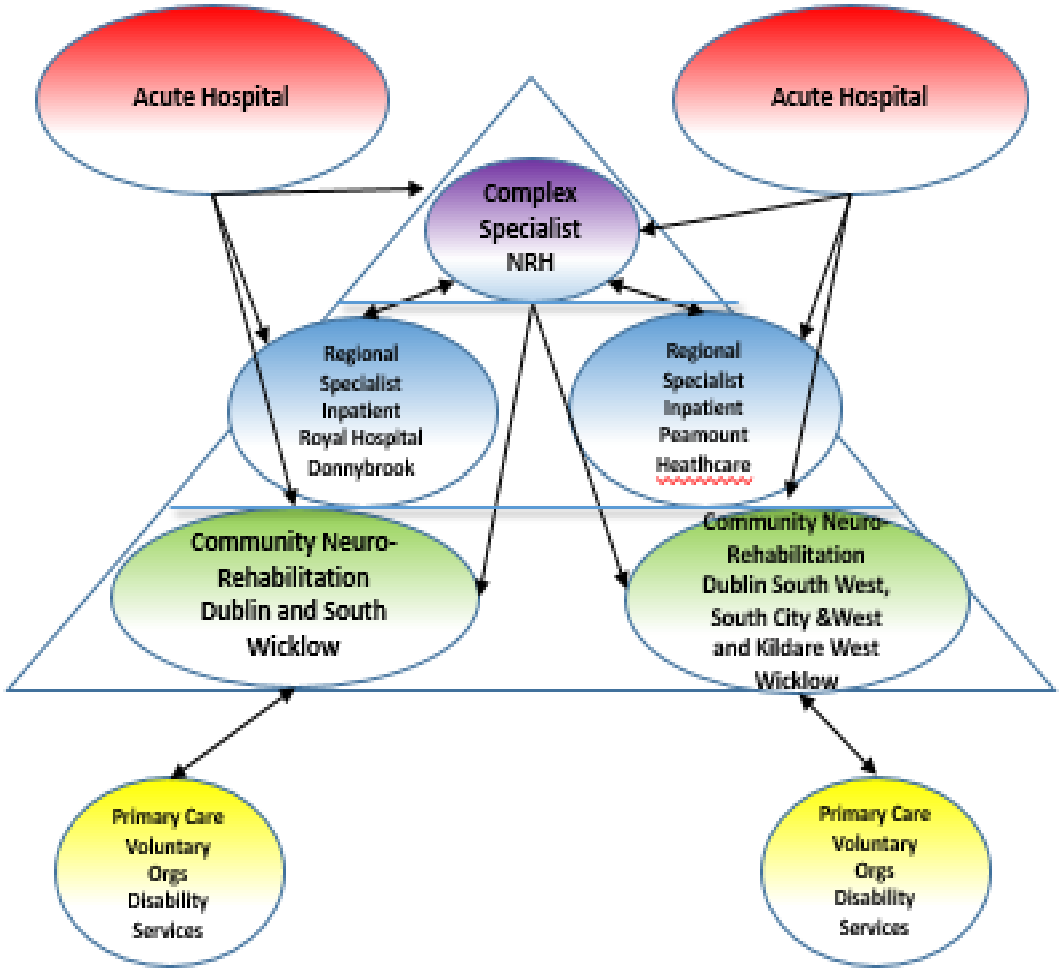
Demonstrator Site

- Network is live since April 2023
- All referrals through Network Rehabilitation Coordinator
- Community Neuro-Rehabilitation Teams onboarding



Partial networks in West and North West and South West

- Community Neuro-Rehabilitation Team onboarding
- Network Rehabilitation Coordinator
- Engage with relevant stakeholders to identify a Regional Specialist Inpatient Service for networks in these regions



Community Neuro-Rehabilitation Team (CNRT)

- Specialised, multi professional teams
- People with complex neuro-rehabilitative needs
- Don’t require an in-patient stay
- Must have rehabilitation goals
- Short period, intensive input
- Up to 12 weeks input

Data Workstream

- Prove effectiveness of MCRNs
- Ensure measuring the correct outcomes
- Create structures for data measurement
- Create structures for data reporting

Community Workstream

- Local HSE managed, advisory and assurance group.

- Representation from acute, community, network, statutory, voluntary sectors, lived experience representatives
- Integration and collaboration

- Tasked with identifying and exploring potential solutions to facilitate integration of network services with existing community rehabilitation services

- Neuro-Mapping Project:

  - Phase 1 highlighted the breadth of voluntary organisation service provision
  - Phase 2: Launched October 2024 - deeper dive into existing services and pathways

In Summary

- Build Managed Clinical Rehabilitation networks.
- Integration and Collaboration is key!
- Local Implementation Groups.
- Person at the centre.

Impact of MCRN Pilot Partial Networks to Date

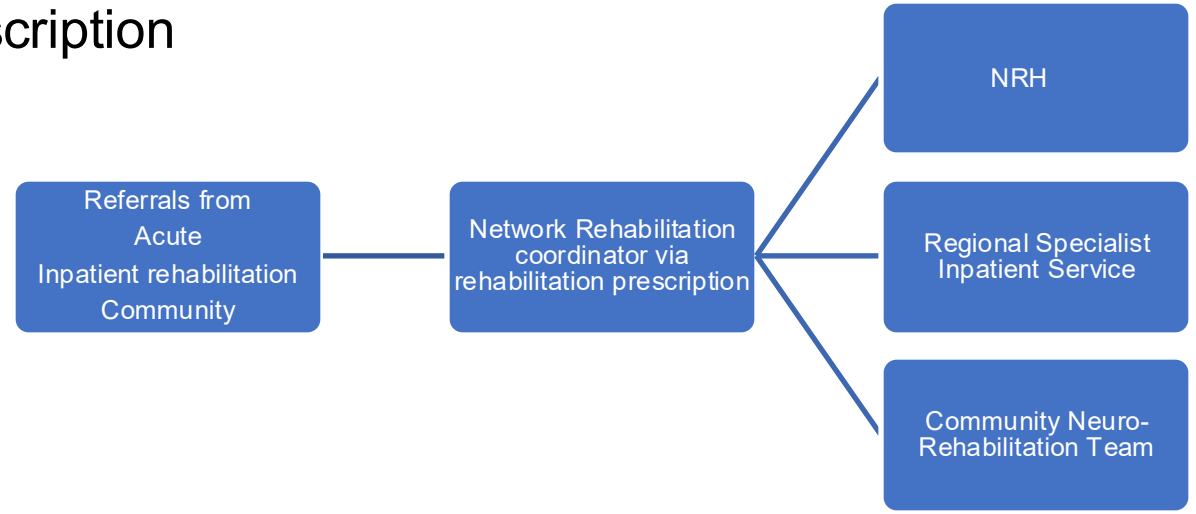
Emma Shortall, Brain Injury and Stroke Programme Manager, NRH
Gina McLoughlin, Network Rehabilitation Coordinator

Role of Network Rehabilitation Co-Ordinator

- Receive Rehabilitation Prescription and decide on acceptance to network within 1 day.
- Direct the referral to the most appropriate service based on the Rehabilitation Prescription.
- Attend MDT meetings in each site to discuss referrals and be informed of decisions made.
- Liaise back to the referrer on decisions made within the MDT in 3 days.
- Maintain data set of KPIs.
- Provide reasons for non-acceptance and suggest other services.
- Should a referrer update the Rehabilitation Coordinator of a patients change in needs, the Rehabilitation Coordinator notifies the original service of the change and redirects the referral to a more suitable network service.

Benefits

- Single point of entry for all referrals
- Single national referral form – Rehabilitation Prescription
- Centralist waitlist
- Reduced duplication
- Transparency of referrals
- Earlier access to appropriate rehabilitation services



Data Collected to Date

- Collected data between January and July 2025.
- Two Health Regions: HSE Dublin and Midlands and HSE Dublin and South East

	Dublin and Midlands	Dublin and South East
No. of Referrals	78	54
Redirected base on change of status	28	11
Suitable for CNRT	27	16

Patient Experience

- Referred to the network on 25/3/25 following spontaneous left intraparenchymal haemorrhage.
- Required Tertiary Services as requiring tracheostomy, suctioning and NG tube
- Monitored by Rehabilitation Medicine Consultant and Rehabilitation Coordinator
- Following decannulation and removal of NG, reviewed.
- Referral redirected to Regional Specialist Neuro-Rehabilitation services based on needs

Bridging the Gap:
An Interagency Community Clinic in Peamount Healthcare

Nuala Crosse, Senior Medical Social Worker
Anne Belton, Clinical Specialist Physiotherapist

Peamount Healthcare

Peamount Healthcare

Regional Specialist Inpatient Neuro-Rehabilitation Service

''The organisation of rehabilitation services should involve greater attention to the process of re integrating clients into the community from the hospital''

Practical Neuro Psychological Rehabilitation in Acquired Brain Injury: 150, eds Newby, Coetzer, Daisley, Weatherhead 2019, Routledge

Peamount Healthcare

Regional Specialist Inpatient Neuro-Rehabilitation Service

Irish Heart Foundation

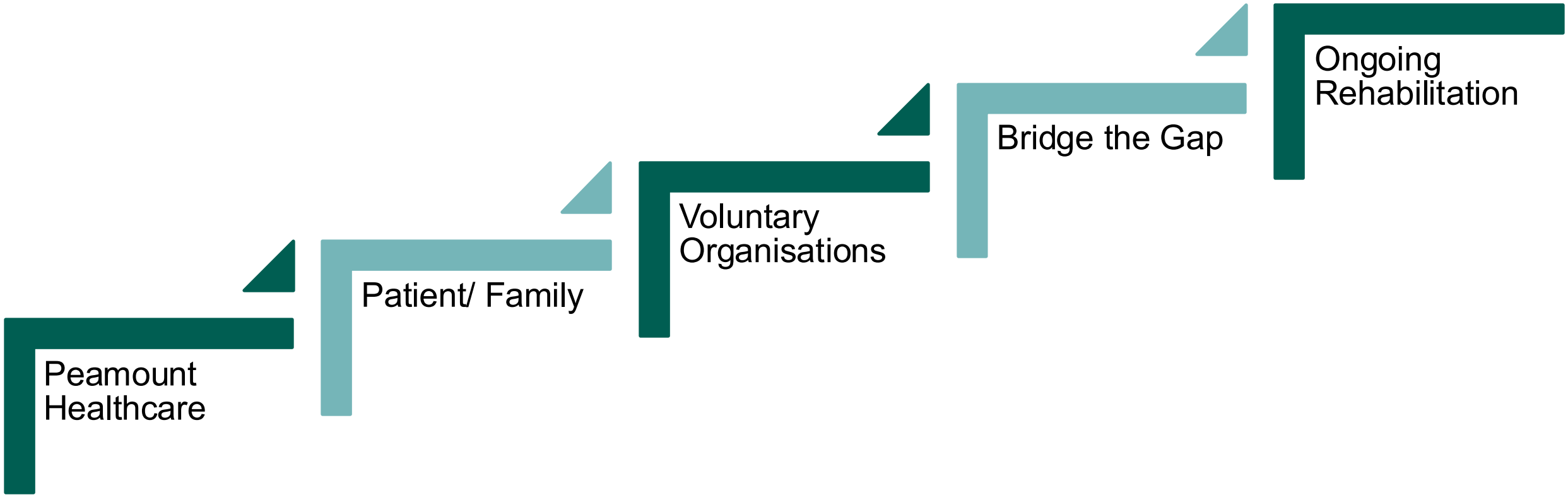
ACQUIRED BRAIN INJURY IRELAND

HEADWAY

Purpose and Principles

- Self-advocacy.
- Active Participant not a Silent Recipient.
- Information – In-Person and Personal.
- Interagency Collaboration.
- Family Relationships.
- Bridge from Hospital to Home on the Rehab Journey.
- A Part of the Rehab Programme.

Aim


Peamount Healthcare
Patient/ Family
Voluntary Organisations
Bridge the Gap
Ongoing Rehabilitation

Set Up

Runs Every 6 weeks on a Monday on Neuro Rehab Ward.

Inpatients meet representatives from Voluntary Organisations.

Runs 10am for 3 hours.

IHF in 1 room.

ABI DSWKWW & Headway in 2nd room.

ABI Midlands attend if patient from that area on the ward.

Key Workers/IDT encourage patients and their families to attend.

MSW facilitates on the day encouraging attendance.

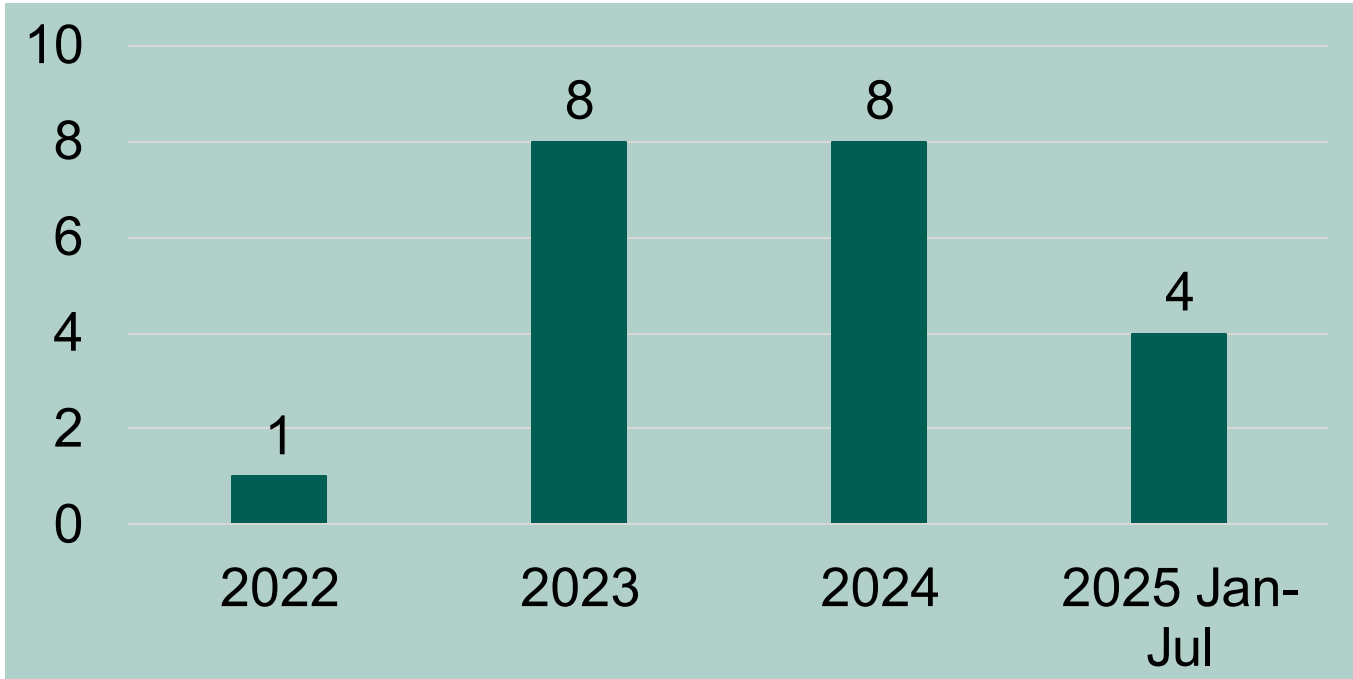
MSW feedback to IDT and Voluntary Organisations.

Number of Clincs

Irish Heart Foundation

ACQUIRED BRAIN INJURY IRELAND

HEADWAY



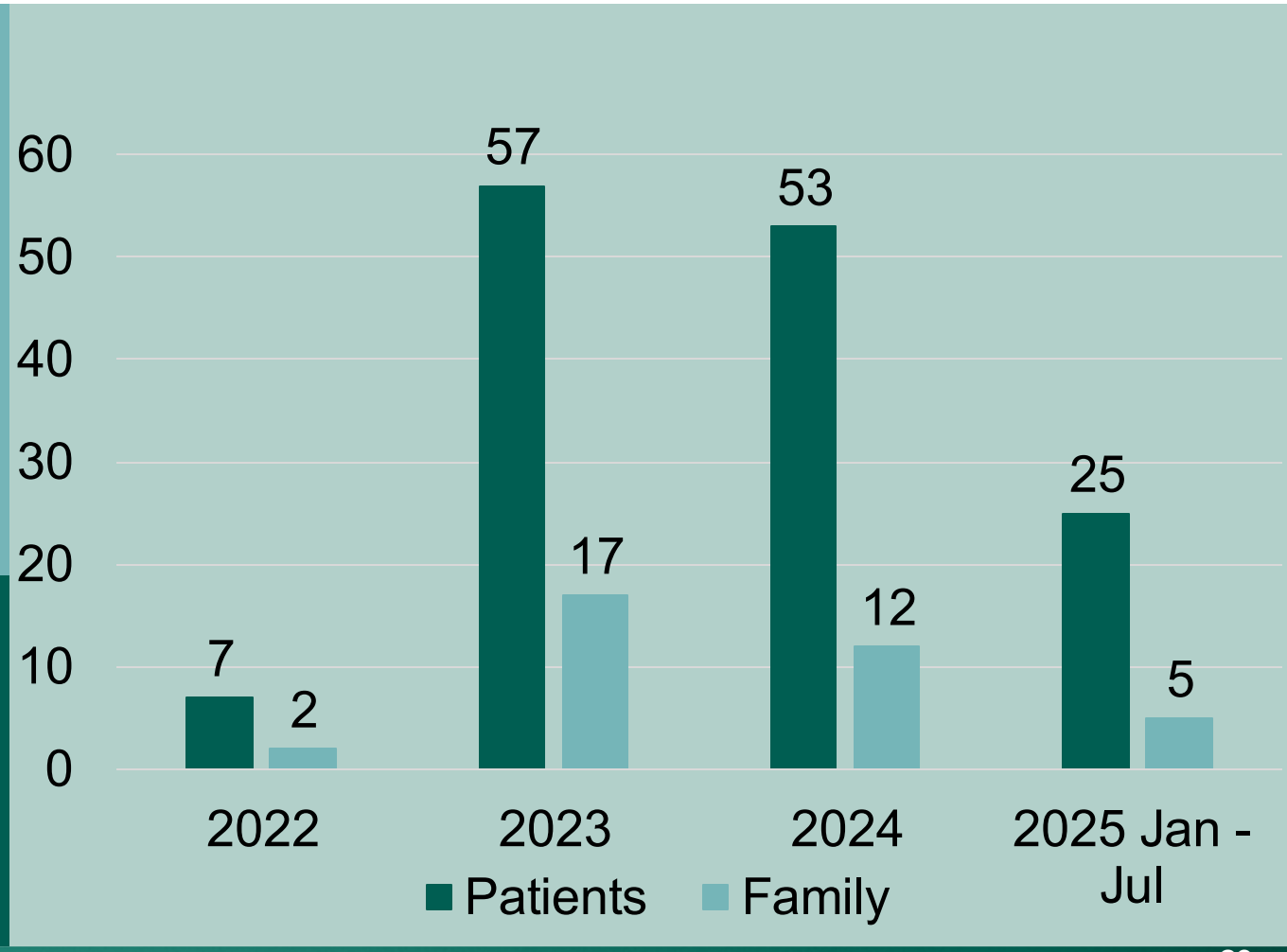
- First clinic pilot in 2022 with ABI.
- Average of 8 per year.
- Total of 21 clinics by July 2025.
- Headway and IHF joined 2023.

Patient and Family Attendance

Average number of Patients = 7 per clinic.

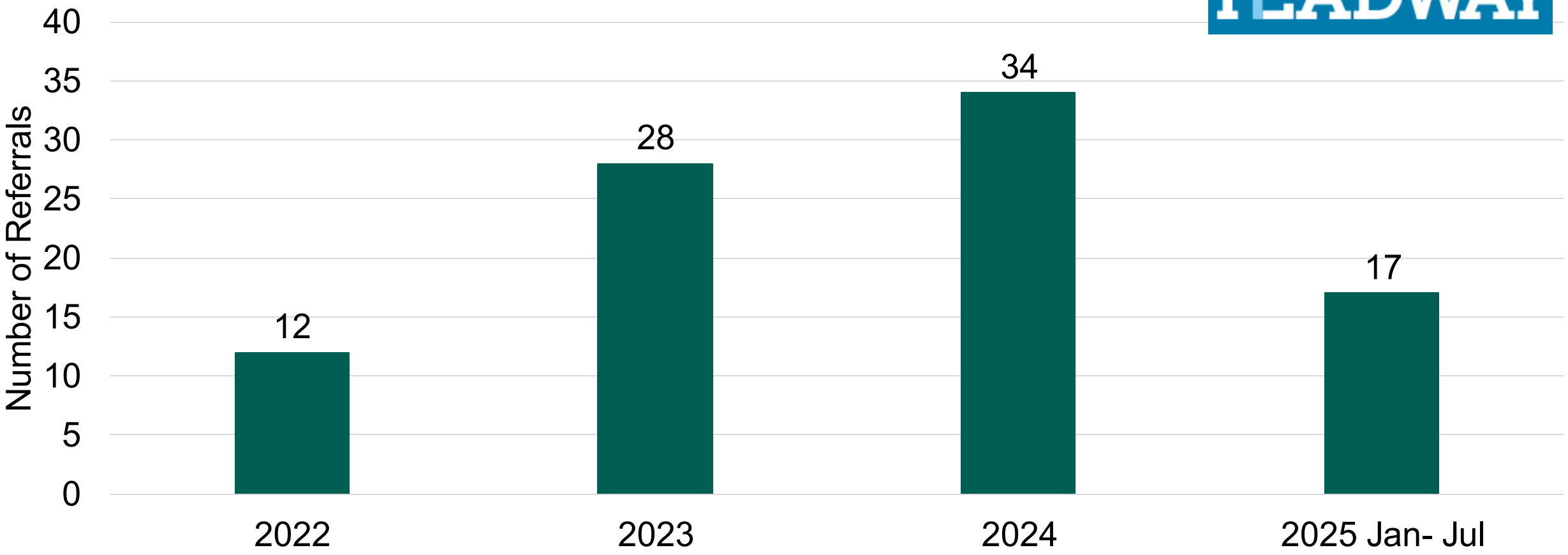
31 Family members have attended.

142 patients have attended.

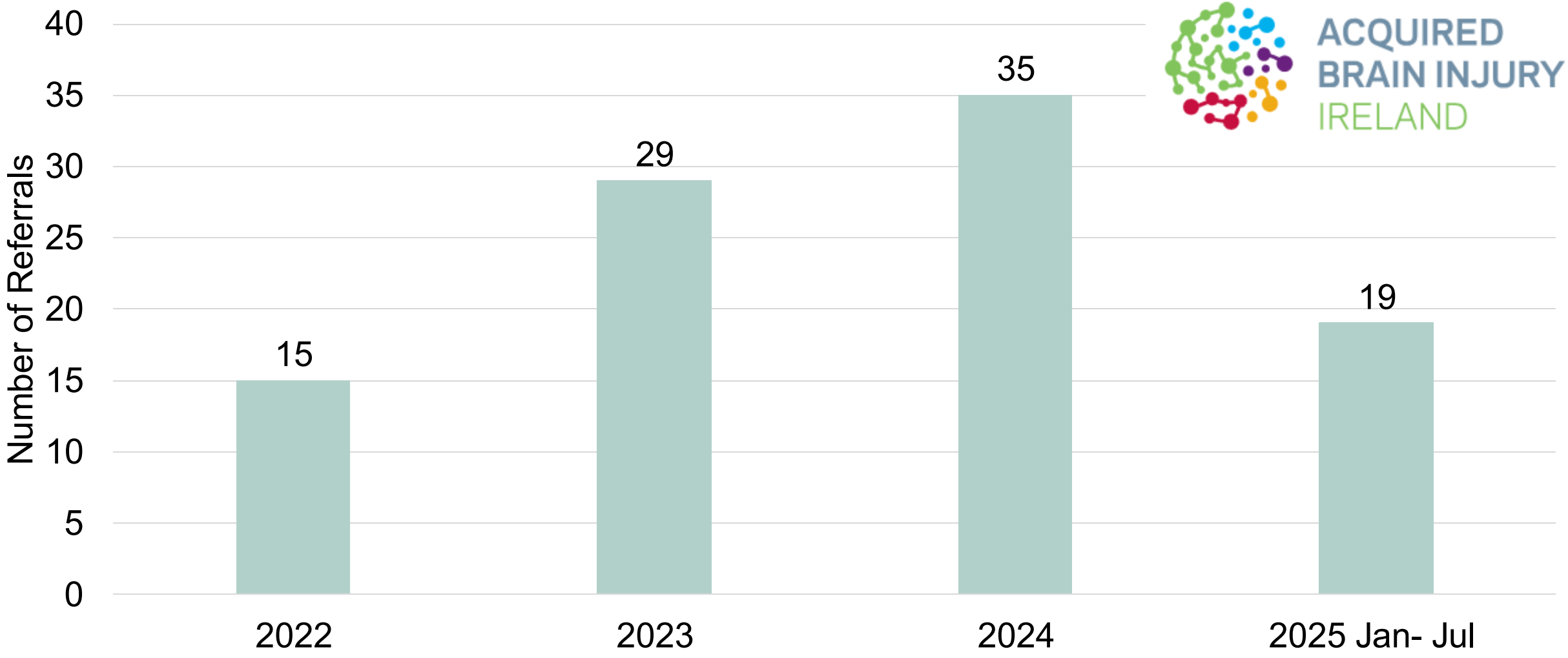


Headway

Number of Referrals

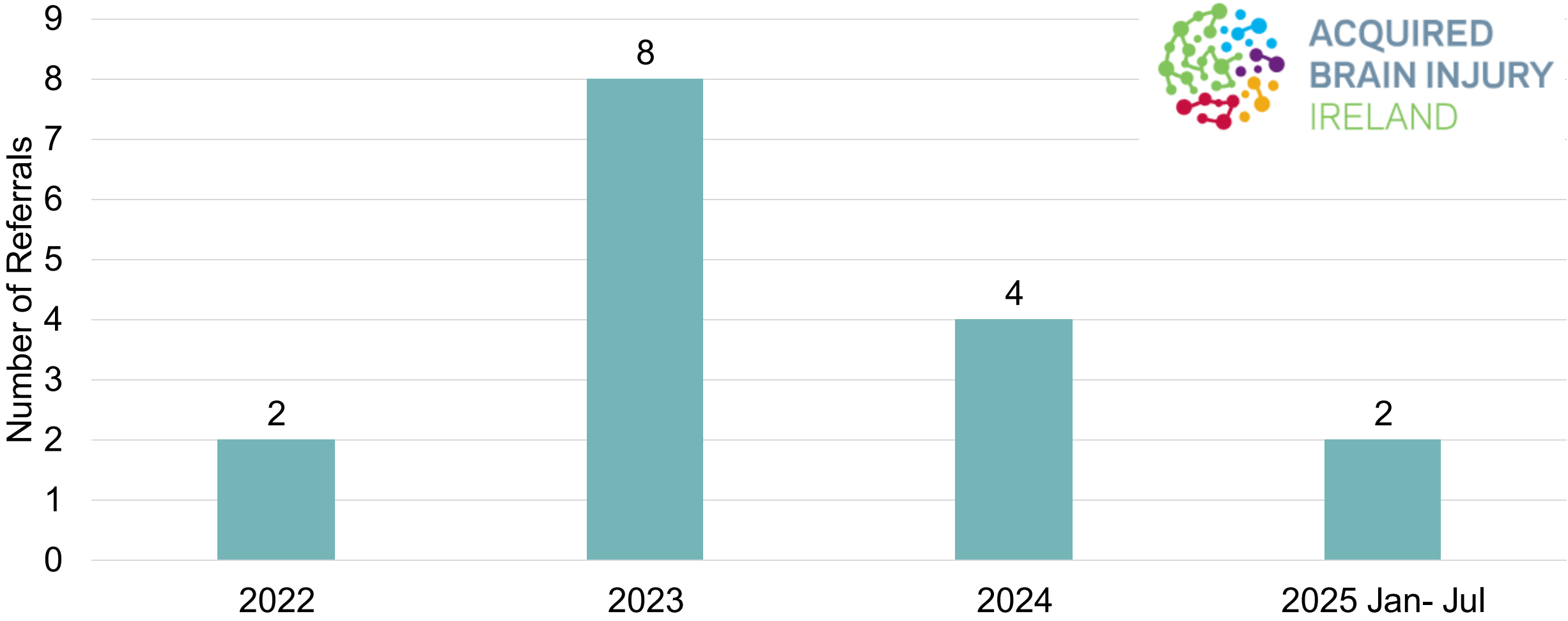


Acquired Brain Injury Ireland DSWKWW



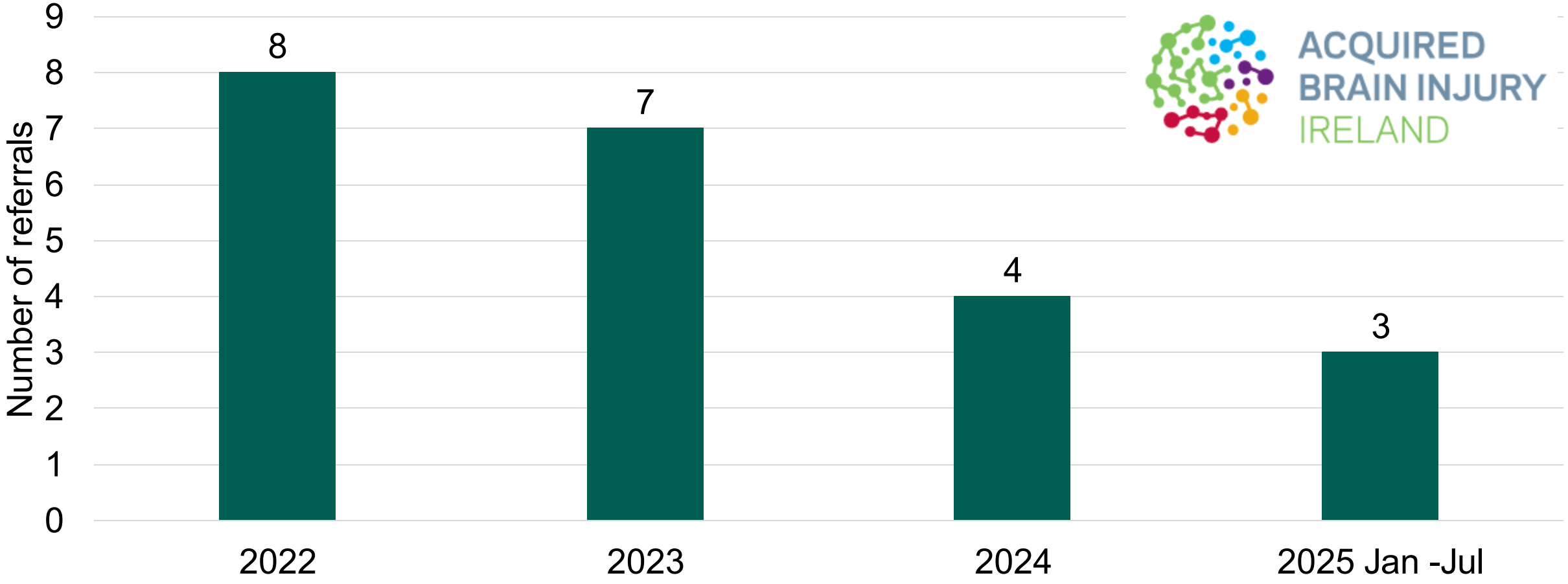
Acquired Brain Injury Ireland Midlands & Other Regions

Number of Referrals



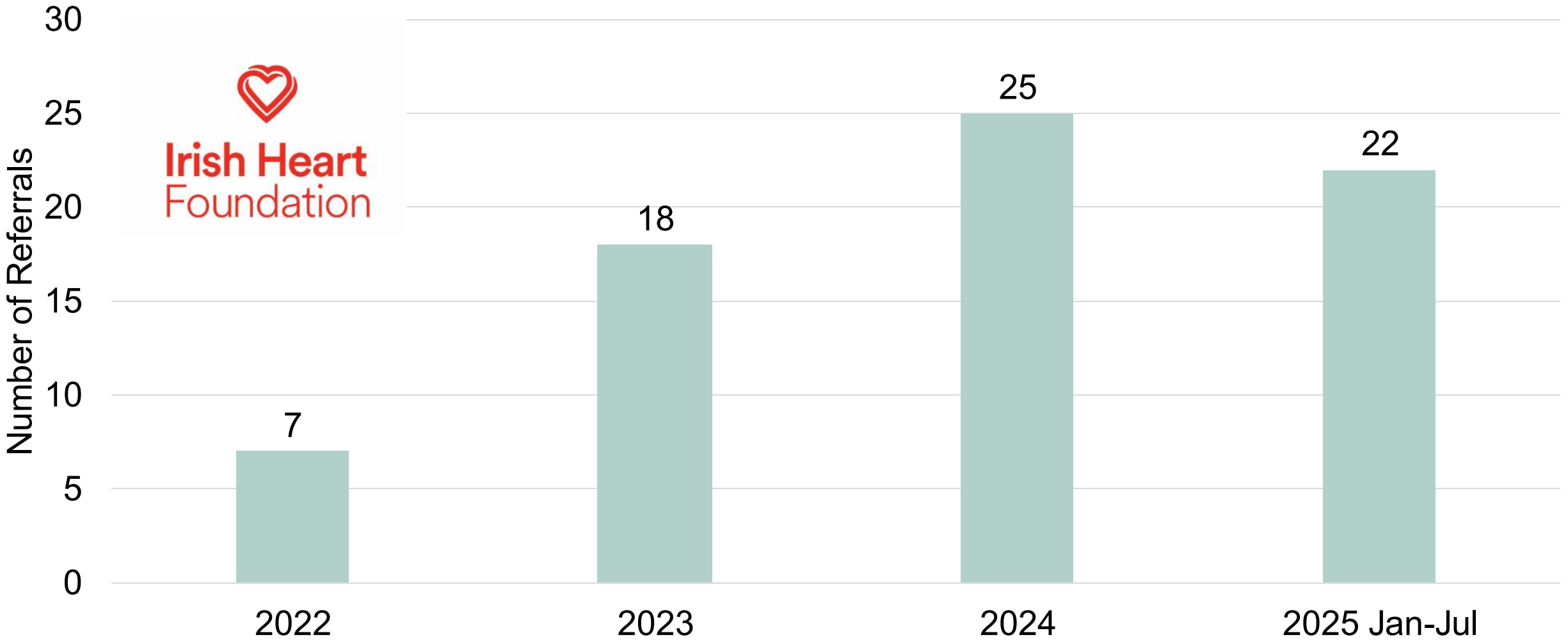
Acquired Brain Injury Step Ahead Referrals

Number of Referrals



Irish Heart Foundation

Number of Referrals



Feedback from a Patient's Wife

‘It also made it much easier to ask questions - without the clinics this info was all just more leaflets and literature to try and trawl through’.

‘they made me feel like we weren't stepping into a vacuum’

‘A face to the services’

‘It made the transition from hospital to home much easier’

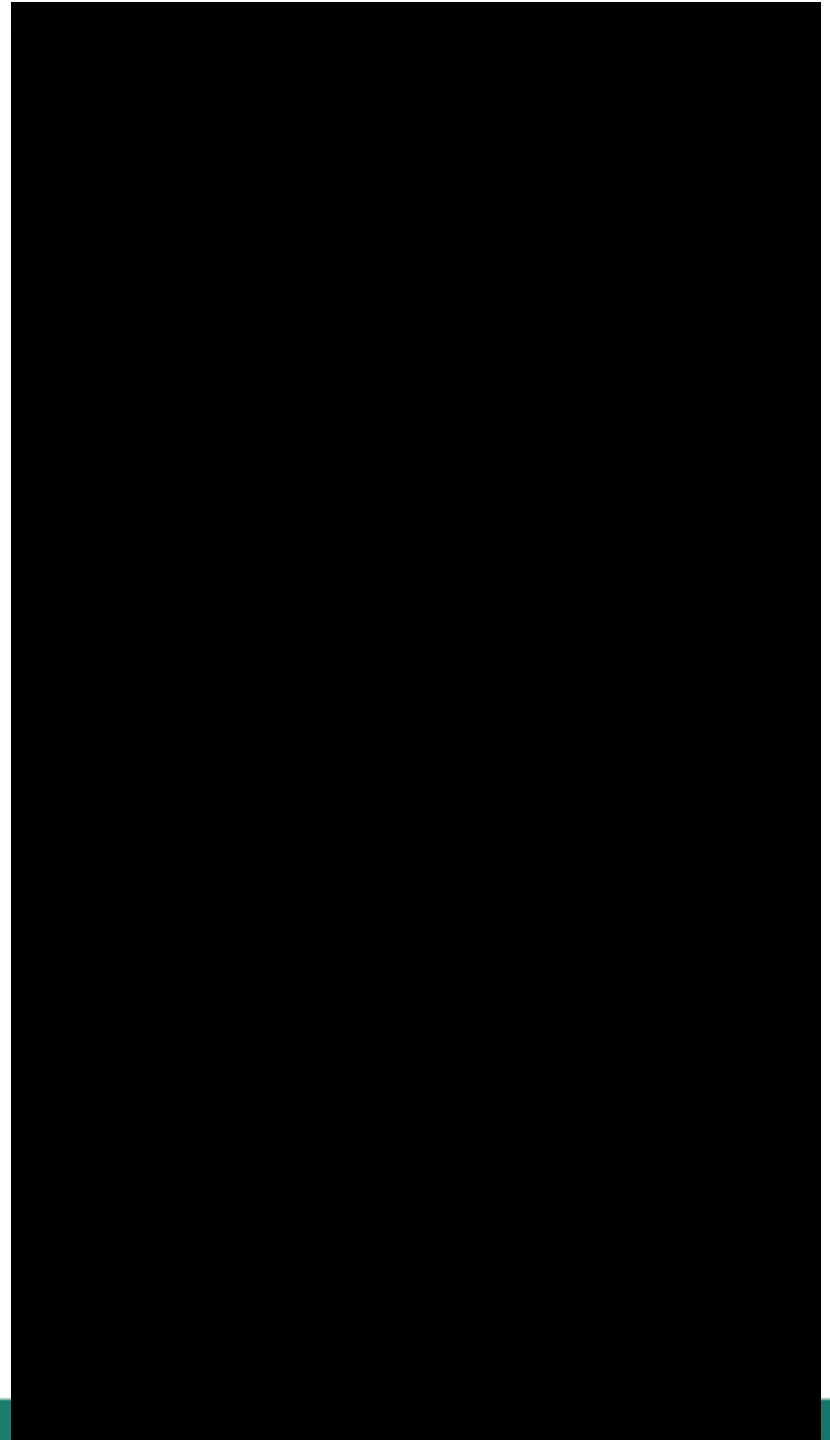
‘Put faces to names and establish a relationship before T was discharged’

Conclusions & Future Directions

- Successful Collaboration between Patient / Family, Peamount Healthcare and Voluntary organisations.
- It demonstrates ‘Sláintecare in action’.
- Highlights the importance of working relationships between hospital and agencies.
- Contributes to bridging the reintegration gap.
- Continue and develop.
- Survey for further Feedback.
- Consider replication nationally.

Thank You

- Carolina Dominguez and Miriam O’Brien – ABI DSWKWW
- Tara Sweeney - Midlands ABI
- Richard Stables and Catherine O’Hare - Headway
- Helena Heffernan – IHF Stroke Connect Service
- ABI Step Ahead – Emer Duffy
- Peamount Healthcare patients and staff



Lived Experience Representatives

Aideen Phelan
Mike Preston
Anne Marie Leonard

Panel Discussion:

National Neuro-Rehabilitation Strategy and Neuro-Rehabilitation Services in Ireland

Closing Address

Aoife O'Donoghue
AND Disability Services