Training Centre in Sub-acute Care TRACS WA

Beyond the Bed: Embedding Rehabilitation Principles

8th March 2013

Program for day

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Welcome and Introduction

- Welcome to our VC participants:
  - Armadale, Bentley, Bunbury, Collie, Geraldton and Swans
- Welcome to our on-site participants

Subacute Care COP: Rehabilitation Introductory Activity … a prelude to goal-setting

What was your New Years Resolution?

- Introduce yourself, where you work and share one of your NY resolutions for 2013 (something you can disclose to the group!)

Group Expectations?

What do you want to achieve from today’s session?

Rehabilitation Components

- Team working
- Self efficacy
- Education
- Evidence based interventions:
  - Functional
  - Task specific
  - Goal oriented
  - High intensity
  - Repetitive
Research shows rehab training has to be:

- Task specific/context practice
- Repetitive
- Meaningful (set goals)

What should each person in the multidisciplinary aim to do?

- Provide evidence-based intervention
- Provide education
- Encourage self-efficacy

Community of Practice Meeting: Beyond the Bed: Embedding Rehabilitation Principles

Rehabilitation: The state of play in WA
Insights from Annette Barton

8th March 2013
AGENDA
Feedback and observations from FIM trainers
- Who - the team
- What — is included in rehab
- How — do we do Rehab

WHO
THE TEAM
- Each patient has their own individual goals
- All team must know patients goals.
- Each profession has own core duties/roles
  - their primary role
- All team member must help each other and
  patient to reach their rehab goals
  - their secondary role
- Need to replicate the patients lifestyle

WHO
- Different professions will be more important
  than others to reach the patients goals
- Must respect and support all professions to
  ensure patients goals are meet.

TAKE HOME MESSAGE
Respect staff roles to achieve patient goals

WHO
- Involves multidisciplinary effort 24/7

TAKE HOME MESSAGE
Whole team needs to encourage independence
24/7

WHAT
Rehabilitation is to...
- reach and maintain their optimal
  physical, sensory, intellectual,
  psychological and social functional
  levels.
- provide the tools to attain independence and
  self-determination.

Functional decline and De-conditioning
How long before a older person starts to decline??
- 1 hour
- 2 days
- 1 week
- 1 month
After being predominately in bed for a fortnight, how much has a person declined?
- a) 10%
- b) 25%
- c) 50%
- D) 75%

For all over 65 yo patients
Age-related functional decline means that older people are more susceptible to de-conditioning.

For all over 65 yo patients
Mobility and self care/domestic tasks are key measures to predict length of stay, discharge destination and support services required.

WHAT
- Need to replicate the patients lifestyle
- Base our treatment on evidence
- Individualize their program as much as possible
  eg shower at night, siesta after lunch, milo/snack before bed

WHAT
- Rehab goals are for the whole rehab process
- Goals are balance between patient centred and hospital/health length of stay and $$. Rehab includes many stages and goals are associated to each stage.
  ED — inpat ward — inpat rehab — outpatients — community

Rehabilitation using ABF
Rehabilitation
- Care Type (Rehab vs GEM)
- FIM (motor and cognition)
- Impairment Code
- Age
  NOT diagnosis
Rehabilitation using ABF

For each impairment code we know the Australian benchmark

- Length of stay
- FIM change

WHAT

TAKE HOME MESSAGE

- Goals balance between patient centred and LOS
- We know the benchmark length of stay for each patient
- We need to assist patient with their goals
- We focus on rehab goals to the setting they are in eg inpatient or outpatient
- Patient goals are individual to them - themselves, their lifestyle, their home, their support etc

WHAT

OUTPATIENTS

- Start on goals where inpatient service left off eg patients ideal goals
- Ask won’t reach goals only Rx/Intervention eg don’t over assess
- Clear expectations to patients eg time limited service
- Skill when to cease treatment and discharge
- Put emphasis on transition to community

HOW

The Rehab team treatment plan

- Exercise alone will not influence hospital LOS
- Cant rely only on Physiotherapy gym program
- Must do combination of exercise + self-care/domestic tasks
- This means we all must pull together - OT, Physio, nursing and TA

Benefits of Functional activities in hospital

- Maintain/improve independence.
- Improve confidence and mood
- Prevent de-conditioning that can result in functional decline
- Maintain/increase muscle strength
- Reduce admission to long-term residential care services.
- Reduce the likelihood of future falls.
- Plus joint integrity, aerobic capacity and Cardio-vas function

HOW

Promote independence in self-care and domestic tasks

Self care - showering, sitting, grooming

Domestic - need to develop this area more

eg making bed, getting towels, tidying drawers, filling water jug, wiping over bed table
Promote independence in self-care / domestic tasks

1. Assist and encourage patients
   - Engage in everyday activity
   - Sitting out of bed
   - Attend Individual and group treatments

2. Educate staff to
   - Provide an environment that encourages independence

3. Supervision for those ‘at risk’

What are we practicing today?

1. Evidence based practice – literature review and application
2. Team-working to increase rehabilitation opportunities and outcomes
3. Goal-setting – incorporating patient education and building in self efficacy

Journal Article Review

The time use and activity levels of inpatients in a co-located acute and rehabilitation stroke unit: An observational study

King A, McCluskey A, Schurr K.
Topics in Stroke Rehabilitation 2011; 18 (1) 645-665.

Analysis of article

- Quantitative observational study
- Observes one unit
- 11 patients
  - Observed using a behavioural map
  - Monday, Tuesday, Thursday and Saturday
  - Between 0800 – 1900
  - 15 minute intervals

Most scientists regarded the new streamlined peer-review process as ‘quite an improvement.’
Literature Review

- 15 studies internationally
  - 38 – 65% of the day alone
  - 5 – 38% of the day with a therapist
  - 34 – 89% of the day in bedroom or sitting room (inactive/passive)
  - 2 – 31% of the day involved in activities to improve function.

The used other units for comparison

- 2 Australian units
  A - 16 patients from 2 general rehab units
    - 14 days post stroke
    - 3/4 weekdays plus weekend
    - 0700 – 1900
    - 10 minute intervals
  B - 64 patients
    - less than 14 days post stroke
    - 2 Consecutive weekdays
    - 0800-1700
    - 10 minute intervals

Study Aim

- Describe time use and activity levels of inpatients in a comprehensive acute and rehab stroke unit.
- Investigate the reliability of recording procedures using multiple observers.

Method

- Ethics approval
- Patient consent
- 20 bed unit – 4x4 bedrooms
  - 4 single rooms
  - Dining room
  - physio gym
  - OT gym
  - Kitchen/Laundry
  
  NB: no mention of bathrooms.

Staff on unit

- 3 FTE physiotherapists
- 2 FTE occupational therapists
- 1 FTE speech pathologist
- 5 FTE nurses per day and evening shift
- No mention of therapy assistants

Participants

- Stroke patients
- Current patients
- Receiving active rehab
- Consented (those with language impairments could have family consent on their behalf)
- 14 patients eligible only 11 consented (3 patients no family available)
- Mean age 71.5
- Time post stroke 29 days (11-71)
Analysis
• Frequencies
• Cross tabulations
• Kappa statistic to determine observation variation

Results
• Overall patients participated in therapeutic activities for 15% of the weekday observations.
• 75% of the observations were classified as passive or sedentary activities eg, sitting, watching TV, reading, writing, eating and drinking.
• What do you think of the classification of passive activities?

People present with patient
• 43% solitary behaviour
• 33% with a visitor
• 12% with a therapist
• 10% with a nurse
• More time in PT than OT and SP

Findings
• Consistent with previous research
• Only spent a small portion of their day with therapists despite the therapists increasing activity before the study
• More active and engaged in the presence of a therapist
• Functional capacity did not effect therapeutic activity

Limitations of study
• Interrater reliability good except when observing patients with expressive dysphasia
• Small number of patients but large number of observations
• Staff used as observers may have affected the amount of therapy offered.

Questions
• What are the clinical implications for your service?
  – Does this unit compare with yours?
    • Similar population?
    • Similar team structure?
    • Similar service (eg IP/OP/ etc)
  – Is the research rigorous enough to make changes suggested from the findings?
  – How could we use this research as evidence to support change in practice?
Practice
1. Evidence based practice – literature review and application
2. Team-working to increase rehabilitation opportunities and outcomes
3. Goal-setting – incorporating patient education and building in self efficacy

Literature tells us:
- Patients are not engaged in adequate amount/type of rehabilitation
- Excessive bed rest
- Majority of the day spent alone and inactive
- Need to practice everyday actions intensively to regain skill in motor performance

But there are many challenges…
to maximising the patients’ engagement in rehab practices at every opportunity, every day.

Rehabilitation Prescription:
- Is a medication chart a useful metaphor?

Rehabilitation Prescription Chart:

<table>
<thead>
<tr>
<th>Prescription</th>
<th>Success Rate</th>
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<tbody>
<tr>
<td>Exercise</td>
<td>95%</td>
</tr>
<tr>
<td>Diet</td>
<td>87%</td>
</tr>
<tr>
<td>Medications</td>
<td>78%</td>
</tr>
<tr>
<td>Sleep</td>
<td>92%</td>
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- What’s the right dosage?
- Assuming active rehab is as important as having medications…. How can we see that the patient gets the dose they need?
Group Work

Mr. X
HPC:
- 50 y/o gentleman with MS
- Diagnosed in 1999
- History of anxiety and depression.
PC:
- Planned admission hospital – DAMA’d after 3 days
- Deterioration in mobility
- Worsening problems with bowel incontinence
- Swallowing difficulties
- Depression and social isolation

Client refused most hospital input, refused to eat during admission.

Referred to RITH and seen by Speech Pathologist and Physiotherapist

RITH speech pathology input
- Frequently coughing on thin fluids & speech unintelligible.
- Education provided
  - on safe swallowing of thin fluids & determining appropriate mouthful size.
  - on maximising voice output and speech clarity - enabled telephone conversations with his son.

RITH Physiotherapy Intervention:
Main Problems:
- Global reduction in Voluntary Control
- Low Mood/Motivation
- Poor mobility and transfers
- Significantly reduced exercise tolerance
- Very socially isolated - limited community participation

Main Goals of Therapy:
- Difficulty identifying goals
- Rehabilitation consisted of: Strengthening, Balance skills, Mobility skills
- Exploring options - Increasing community participation. Attempt to get some "buy in" to a self initiated rehabilitation program.

Main Outcomes/Achievements:
- Participating in a home exercise programme.
- Started using an electric wheelchair to access the outdoors.
- Continues to decline ongoing referrals but happy to participate with RITH if re-referred
- Insight into how devastating MS can be to a person’s ability/drive to participate in life!
Mr J

30yo adm RPH stroke unit 22/8 - 6/9/12 with Medullo-pontine haemorrhagic stroke – L hemiparesis, L facial droop
- B/G – HTN, Chronic renal impairment

On discharge from ward 8A LOS (2 weeks) to RITH:
- Independent stand step t/f to chair
- 2xA ambulating on ward

RITH Physiotherapy Intervention:
Main Problems:
- Left Hemiparesis
- Alterred gait pattern
- Limited ability to walk around home - required assist/supervision x1
- Unable to access the greater community

Clients main Physiotherapy Goals:
- Achieve independence with all aspects of mobility
- Achieve independent community ambulation
- Return to leisure/recreational activities

Main outcomes/achievements to date:
- Walking indoors/outdoors independently
- Able to hop, skip and jump
- Able to run

Current Scores:
- Berg Balance: Initial = 47/56, Current = 56/56
- FIM: Initial = 109/126, Current = 126/126
- Chedoke McMaster Motor Recovery
  - Initial: Hand = 6/7, Arm = 6/7, Foot = 4/7, Leg = 4/7, Postural Control = 5/7
  - Current: Hand = 7/7, Arm = 7/7, Foot = 7/7, Leg = 7/7, Postural Control = 7/7
- 6 minute walk test = 541 meters

RITH OT input
Goals
- Improve grip strength (left hand dominant), Motor skills, and typing skills.
- Improve ability to participate in ADL’s

Outcomes
- Independent with meal preparation, all ADLs, all dressing, can tie up own shoe laces, improved touch type (62 per minute)
- Returned to work – reduced hours.
- Independent use of public transport

"Just wanted to thank you again for all the help you were during my time at RPH. Thank you for organising the ESD home visit with Lynsey and your help with getting me home with RITH rather than having to go to Shenton Park, the wheelchair and shower chair which are a great help, and all the therapy.

It’s been good to be at home enjoying home cooking, being in a familiar environment with family and just doing all the things I would do at home that I couldn’t at hospital.

The rehab is going well. Rod came out on Friday, and Alison came today. There have been noticeable improvements every day, and now I can walk around the house unassisted. My left arm is also a lot better – strength and coordination are improving (I can touch type now though slower than I usually would and with more mistakes). Kenny the OT visited today and suggested I continue with the writing/drawing exercises you supplied. He also suggested using some typing software to log improvements in my touch typing. He will also send some putty home tomorrow to help improve hand strength. So thanks once again!

God bless,

P"
Goal-setting

Summary of article:

Rosie, 52yr, stroke 8 weeks ago, mild hemiparesis of right side (right side dominant). Lives with husband who works fulltime. Likes walking her dog. Household chores previously her responsibility.
What do we do with our patients?

- Is it work that
  - The patient is willing to pay for?
  - Improves the things that the patient cares about?
  - Is done right the first time?

Data can be used for clinical decision making and improving Rehabilitation care

- Identifying the key problems or areas of improvement
- Setting goals/targets for improvement
- Engaging/motivating staff
- Evaluating the impact of interventions

A process to collect the data

- Standard Operating Procedure for FIM Meetings
- Standard Operating Procedure for MDT Meeting Record Sheet
- FIM Stickers – one location, less wasted travel time
Visual Performance Measures

Asking questions about data
E.G. Analysis of patient improvements in function through the Quality of Care Registry (QoCR)

A place to have conversations and learn from each other
E.G. Statewide Quality and Activity Data Group (Aged and Continuing Care Directorate)

The role of standardised count through benchmarking groups
E.G. Australasian Rehabilitation Outcomes Centre (AROC)

Data facilitates clinical improvement and improves care for your patients!
- Use a quality improvement cycle
- Plan carefully
- Learn from others
- Try things out to avoid mistakes
- Involve the team and consider impact on normal work flow
- Don’t be afraid to ask for help

https://activity
Managing in an ABF Environment Workshops
Summary and conclusion