

SUGGESTIONS FOR IMPROVING REHABILITATION SERVICES IN GLASGOW: DISCUSSIONS WITH NINE SENIOR THERAPISTS

In 2003 David Walker, Pamela Ralphs and John Womersley each conducted three semi-structured interviews with three senior physiotherapists. Detailed summaries of these discussions are given in Section B. The comments and suggestions made included the following:

Assessing the disabled person's needs

In Scandinavia the focus is entirely on how to help the disabled person to get on with life: on enablement and minimising disability rather than on measuring disability and arranging for support services.

Any one member of the rehabilitation team should be able to conduct an interdisciplinary assessment – on behalf of all members of that team.

The patient must be central to the goal planning process. Professionals are often more fearful of discharge than patient.; professionals need to have confidence in patient's ability to assess own needs.

Much more focus is required on employment issues.

Assessment protocols such as Carenap-E do not take account of dynamic changes in mental, physical and social function that occur naturally and which are also the aim of the rehabilitation process itself. Also far too complex/time consuming in A&E etc.

The starting point with a patient should be to determine what he or she wants, and then to discuss the possibility of this being achieved - and how to do so. It is important assess with the patient what improvement may be possible, and all members of the team should be trained to think in this way.

Changes in working practices

There should be considerable further development of rehab assistants working across disciplines (OT, SLT, physio) rather than in one discipline only. Rehabilitation assistants if adequately trained should be able to undertake most tasks apart from initial assessments.

More use should be made of carers and of support workers – which requires training. There should be less emphasis on numbers 'treated' and more on measuring benefit achieved. The 'boundary' between primary and secondary care also requires to be eroded.

There should be facilities for creative and other group therapies, including exercise and balance training and other aspects of health promotion..

For those with severe long-standing impairments, prevention of avoidable complications and the maintenance of function and of social participation is often a more important objective than the enhancement of physical or cognitive function.

Creativity can be stifled by lack of management support. Clinicians become despondent when there is little support for their ideas. This leads to diminished enthusiasm and reluctance to work up new initiatives for fear of wasting time and resources. It is often hard to know where to take new ideas to, and there is fear of “getting into trouble”

The team should operate in an interdisciplinary rather than multidisciplinary way. . Otherwise effectiveness is diminished and time wasted in trying to contact other professionals.

Patients need better information about managing their condition, and quicker response.

Homecare should be delivered quite differently – focusing on helping people to do things for themselves rather than on doing things for people.

Increasing efficiency

There is a great deal of time wasted in creating paper documentation, making referrals etc. With appropriate and adequate IT a great deal of time could be saved – also automating referrals and making pathways and choices clear to patients.

There is an urgent need for research to establish the relative effectiveness and cost-effectiveness of new and existing interventions and of patterns of service co-ordination, management and delivery. The implementation of service registers in a form acceptable to disabled people and the adoption of standard outcome measures would facilitate service management, clinical audit and staff development.

It is important to develop or adopt a system for managing care, demonstrating effectiveness and planning service delivery ‘Care Aims’ is one such system which has been used to good effect in England and some places in Scotland including Glasgow.

A more effective interface is needed between services for children, younger adults, and older people.

There are many examples of innovative good practice throughout GGHB and these should be advertised and their replication encouraged.

Unless there is minimal delay in assessment and therapy provision, the ‘window of opportunity’ for rehabilitation is lost.

Consider a seven-day service for some areas. A five-day service is fine for most activities but there is a need to improve holiday cover issues.

Rotational posts at lower grades should be developed; this would break down barriers between services.

There is a need for improved communication/joint working between doctors and therapists. Therapists should be given more responsibility, not only for discharging patients but also for leading teams (e.g. at PDRU).

Involvement of patients, care staff and family members

Patients should be given the opportunity and encouragement to take as much responsibility as they wish (and are capable of) for the management of their own condition.

Care staff and relatives should be encouraged to continue with therapies between visits by professionals.

Should encourage older population to be active: Tai-chi etc.

Standards

In order to provide a good standard of medical care to people with physical and cognitive disabilities, the following professional competencies are essential:

- The ability to evaluate a disabled person's rehabilitation potential, taking account of their medical, personal and environmental circumstances.
- The ability to define and negotiate a rehabilitation plan with the disabled person, informal care givers, professional staff and others who may contribute to the implementation of the plan.
- The ability to revise and monitor the outcome of a rehabilitation plan in the light of changes in the level of disability, or changes in the disabled person's wishes and circumstances.

Issues specific to Glasgow Royal Infirmary

GRI requires an OT outpatient service: all other hospitals have OT outpatient facilities.

GRI also runs a weekday only rehabilitation service. This wastes three days of rehabilitation, with Monday being taken up in trying to restore the function achieved on the preceding Friday. Patients as well as staff see this as unsatisfactory. The situation is even worse over public holidays. Posts which employ a single individual are also a problem since there is no cover for periods of leave. Most therapy posts should be recruited on a 1.2 wte rather than 1.0 wte basis.