An Effective Strategy to Optimize Rehabilitation in Long Term Care

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Introduction

There is a growing body of literature supporting the benefits of an active rehabilitation approach in long term care environments. Telenius et al (2015) reported that rehab programs can significantly improve cognitive and ADL functioning of people in long term care with dementia. The results of an Alberta study explored the outcomes relating to enhancing access to OT and PT in a 200 bed long-term care facility to a ratio of 1:50 beds. Results showed that enhanced OT/PT services were more effective at promoting, maintaining or limiting decline in functional status at 6, 12 and 18 months compared to a control group that had a ratio of 1: 200. Specifically, residents in the enhanced group performed better on self-care tasks (e.g. feeding, grooming, bathing, dressing, toileting) mobility, communication, cognition and psychosocial adjustment. A 2013 Cochrane review, *Physical rehabilitation for older people in long-term care* concluded that there is "evidence that physical rehabilitation interventions for elderly people residing in long-term care may be both safe and effective, improving physical and possibly mental state. However, the size and duration of the effects of physical rehabilitation interventions are unclear. Although physical rehabilitation may be beneficial for care-home residents, the specific type(s) with most benefit, and how these relate to resident characteristics, is unclear."

Historically, the challenge for occupational therapists to deliver such programs is limited availability of resources in part due to funding formulas, lack of clear role definition, and professional isolation due to small FTE's and challenges with recruitment and retention. The development of occupational therapy programs and services in residential care environments is often left to individual clinicians to develop and can be influenced by team members understanding and expectations of an OT's role in LTC (e.g. wheelchair prescription). Patient based funding trends in Canada also put administrators and clinicians under increasing pressure to deliver effective rehabilitation services with scarce sector resources.

A 2011 therapy services review was conducted to identify the gaps and service challenges in the delivery of therapy services at Bethany. The need for a review was identified in part due to feedback from residents in a previous project. Findings from this review included:

- Lack of organization wide service delivery model
- Ongoing recruitment and retention challenges for OT which impacted resident access to rehabilitation
- Lack of professional practice support, especially for staff working at smaller sites resulting in feelings of isolation
- Lack of role definition resulting in frustration, especially during the first few months after being hired; therapists felt they were left on their own to define their role

Within the PCBF funding model Bethany recognized the importance of identifying appropriate residents to participate in active rehab programs (150 min/ 5 days per week) and to ensure that rehabilitation staffing resources are deployed as efficiently and effectively as possible. Timely recruitment of appropriate resources to deliver rehabilitation services was also identified as a priority.

Objective

A quality improvement approach, utilizing RAI data, clinician engagement and best practice review was used to develop a population based outcome oriented Occupational Therapy Service Model for LTC which included practice tools and protocols. The strategy defined the following objectives:

1. Develop **service delivery framework** for OT and PT which is evidence informed and provides clarity for rehabilitation service delivery for key resident populations.
2. Streamline **admission assessment** of residents to ensure timely identification of residents who may benefit from an active rehabilitation program, identify areas for further specialized rehab assessment and consultation.
3. Develop clear **program protocols** which target residents who may benefit from an active therapy which meet the CIHI definition for Rehab RUG (150 minutes over 5 days minimum). Programming delivered by rehabilitation assistant under the direction of an OT or PT.
4. Revise and **streamline job descriptions** to better reflect skills, knowledge and roles for OT/PT and therapy assistants. Ensure consistency across sites re role expectations.
5. Streamline **recruitment** efforts for rehab staff with the goal of having appropriate rehab staffing model to implement programs. To recruit **physiotherapy** staff at Bethany Calgary and Collegeside.

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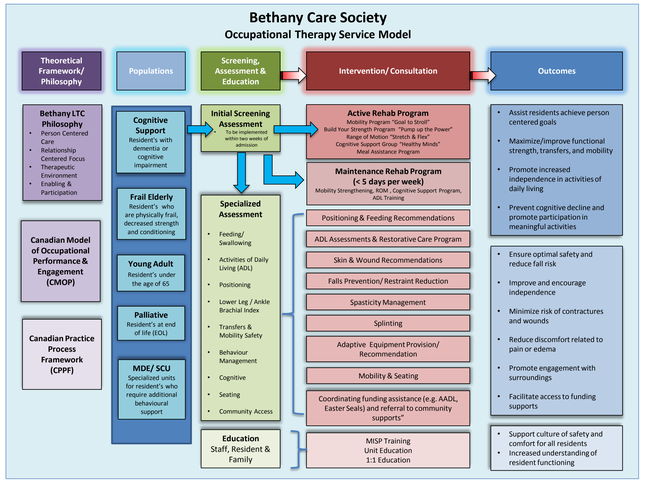
CREATING CARING COMMUNITIES

Outcomes

1. Development of an OT service model which links program philosophy, defined resident populations, 3 main practice areas (screening, specialized assessment and education), interventions (Active & maintenance program, consultation and education with outcomes)



2. Initial OT/PT Screening Assessment developed and is completed within 2 weeks of admission. Assessment identifies high priority areas and areas for further assessment to be completed at a later date.

3. Program Screening criteria to assist facility to identify potential residents appropriate for active rehabilitation. To implement the program all residents were screened by care service managers and RN based on core RAI data (CPS, ADL). OT reviewed screening information and determined appropriate residents for program.

Active Rehabilitation Program Screening Form

Active Rehabilitation Programs are intended for residents who have the potential for functional improvement.

Please complete and refer to OT/PT. A therapist will complete an assessment to determine whether the resident is appropriate for the program. Based on most recent RAI/MDS assessment (except new admissions) please record:

- MDS Outcome Score [ADL Long Scale] Score _____ (Target Range 4-19)
- CPS Score: _____
- MDS ADL Functional Rehab Potential Score (GB-Full Ax): Checked: a___ b___ c___ d___
- MDS Change in ADL Function Score (G9): Score _____ Checked: 1___ 2___

Mobility Program/ Strengthening Program	ROM Program	Cognitive Support Program
☐ Resident has experienced decline in mobility and/ or functional strength in the past 3-6 months	☐ Resident experiencing decrease in their ROM affecting performance in their ADLs	☐ Residents has mild-moderate cognitive impairment
☐ Resident had recent fall with injury (potentially due to weakness , deconditioning, poor balance) (last 3- 6 months)	☐ Resident has contractures that may be affecting positioning, causing pain, difficulty providing care or increasing risk of skin breakdown	☐ Resident is willing to participate in group activities and may benefit from increased daily structure and group participation
☐ Resident is a moderate-high fall risk (FRA)	☐ Resident has a diagnosis of CVA	☐ Residents able to understand the facilitator and communicate within the group
☐ Resident is has had a recent CVA (6 months)	☐ Resident has a diagnosis of brain injury	☐ Resident has ability to follow one-step commands
☐ Resident has impaired functional mobility and/ or strength following to acute illness, recent fracture or surgery (e.g. hip, knee)	☐ Resident has a diagnosis of Rheumatoid Arthritis	☐ Resident able to attend for minimum 20-30 minutes at a time
☐ Resident requires assistance to ambulate	☐ Resident has a diagnosis of other neurological disorder	☐ Resident has the ability to participate appropriately within a group setting
☐ Have a CPS score of ≤ 3	☐ Resident experience tone or spasticity in extremities	☐ Resident has a CPS score of ≤ 3
☐ Resident has the goal and desire to improve mobility , transfers and or ADL performance	☐ Resident has goal and desire to improve their functional ROM	☐ Resident has goal and desire to improve their cognitive skills

Outcomes

4. Active Rehab Program protocols developed. The programs goals were communicated to the unit teams. The protocols assist the therapists in defining SMART goals and criteria for discharge or transfer to maintenance program. The protocol also supports OT orientation process by ensuring consistent application across all sites.

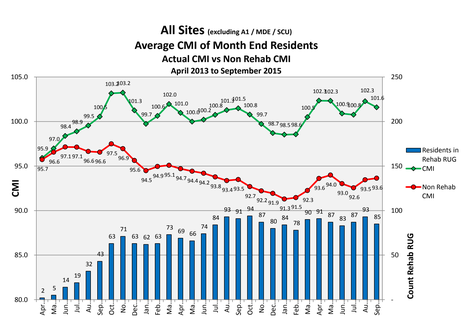
ACTIVE REHABILITATION PROGRAMS (Summary)

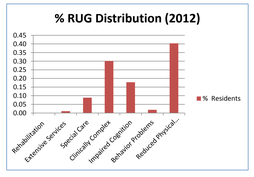
PROGRAM NAME	*"Goal to Stroll" Mobility Program*	*" Pump up the Power" Program Strengthening Program*	*Stretch and Flex Program (ROM program)*	*"Healthy Minds" Cognitive Support Group Program*
POPULATION	Frail Elderly Young Adult	Frail Elderly Young Adult	Frail Elderly Young Adult Cognitive Support	Cognitive Support
GOALS	*To promote improvement in resident's functional mobility by improving physical and emotional aspects of mobility (ambulation and wheelchair mobility)* The program addresses barriers to safe mobility and aims to Improved distance walked, greater reported self-confidence and decreased fear of falling.	*The goal of this strengthening program is to assist residents to achieve improvement in functional strength with the aim of generating improvement in ability to transfer and participate in Activities of Daily Living (ADLs).* The program focuses on improving upper and lower body strength, core strength, and/or balance with the intention of improving ADL performance.	*The goal of this ROM program is to prevent further decline of ROM in order to provide ease of care and/or reduced pain.* The program focuses on improving active range of motion (AROM) in order to achieve increased independence in ADLs. To prevent skin breakdown due to contractures of joints.	*To provide residents with cognitively stimulating activities and/or a sense of purpose of mediating further decline in cognitive ability. To improve symptoms of depression and anxiety. To improve performance in ADLs for some residents.* This activity based group program focuses on targeting cognitive and psychological skills and maximizing residual function
DURATION/ FREQUENCY	• 3 months to a year • Re-assess minimally at each quarter.	• 3 months to a year • Re-assess minimally at each quarter.	• 3 months to a year • Re-assess minimally at each quarter.	• 3 months to a year • Re-assess minimally at each quarter.
SCHEDULE	• Intervention to be provided 3-5 times/week for 30 minutes. • Goal to Stroll program can be paired Some residents may benefit from attending the walking program in addition to a strengthening program.	• Intervention to be provided 2-5 times/week for 30 minutes. • Pump up the Power program can be paired with other active rehabilitation program • Some residents may benefit from attending both the walking program and strengthening program (i.e. Walk 3x/week and do strengthening exercises 2x/week).	• Groups at least 30 minutes in length. • Some residents may benefit from participating in individual and group ROM programs. • Group Ratio 4:1	• Facilitator to run a two-week schedule of a variety of activities that can repeat after every 2-week period. • Once a month a larger group activity • 30 min group, 5 days/week. • Group participants will attend the group for six months to a year depending on their tolerance and progress.

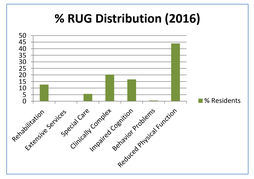
5. Two-day Therapy Assistant workshop was developed by therapists and was mandatory for all TA's. Workshop provided training to ensure consistent understanding of expectations.
6. Documentation tools develop to ensure accurate capturing of therapy minutes and to ensure TA's are clear about resident goals. Minutes and entered electronically into Point Click Care.
7. A new position was created - Allied Health Practice Coordinator & Educator to support professional practice.

Results

- Active Rehab Program implemented across all sites.
- Increased number of residents involved in ARP
- CMI better reflects program
- Shift in RUG distribution







Future Directions

1. Review of resident specific outcomes
2. Examination of resident /family satisfaction
3. Exploration of other program development opportunities, including strengthening collaboration with recreation therapy

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