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In Practice: An innovative occupation-focussed service to minimise deconditioning in hospital: Challenges and solutions

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This paper describes the challenges and solutions that one occupational therapy service has experienced during the implementation of an innovative program that aims to reduce risk of deconditioning during hospitalisation. While hospitals are usually viewed as places where health is restored, being hospitalised is also known to have health-damaging effects, particularly for older people. Eyres and Unsworth (2005) describe that a patient's health can decline as a consequence of being hospitalised, not just as an effect of the medical condition itself. These authors note that deconditioning during hospitalisation can occur due to experiences of occupational disruption, and characteristics of acute hospitals, which reduce a patient's sense of control over his or her environment. Although there is evidence regarding the detrimental effects of hospitalisation for older people (Inouye et al., 1999; Sager et al., 1996), there have been limited programs to counteract this phenomenon. Furthermore, programs cited in the literature have largely focused on physiotherapy interventions (Siebens, Aronow, Edwards & Zahra, 2000), while occupational therapists' perspectives are far less evident.

Occupational therapy that is in practice occupationally focussed, may have much to offer older persons who are at risk of becoming deconditioned during their hospital stay. Since the 1960s, some occupational therapy leaders, such as Mary Reilly (1962, 1966) have advocated that occupational therapy should be focussed on occupation. Occupational therapy is currently experiencing an 'occupational renaissance' (Whiteford, Townsend & Hocking, 2000), also described as a paradigm return to occupation as core practice (Kielhofner, 2004). Such philosophical visions are fuelling rekindled interest in how occupational therapists can focus upon occupation in their everyday practice. In addition, there is an increasing evidence base to support

theoretical assertions about the link between engaging in occupation, and health and wellbeing in older people (Glass, Mendes de Leon, Marratoli & Berkman, 1999; Iwarsson, Isacson, Persson & Sihersten, 1998; Law, Steinwender & Leclair, 1998). Clark et al. (1997) completed very convincing research, linking occupation to health, in the *Well Elderly Study*. In this randomised controlled trial involving 365 people, the researchers found that there were significant benefits to health, function and quality of life domains for study participants who received occupational therapy treatment. Clark et al. concluded that preventative health programs utilising the treatment and expertise of occupational therapists might mitigate against commonly occurring health risks experienced by older persons.

In its attempts to 'live the vision' of occupation-focussed practice, the 'Functional Conditioning Program' (FCP) which is based within a large acute hospital in Melbourne, and is a joint initiative of the Occupational Therapy and Physiotherapy Departments, was initiated. Physiotherapy interventions include individual and group-based exercise programs and mobility practice. Occupational therapy intervention provides opportunities for people to engage in individual and group based interventions focused on their usual occupations, including self-care, productivity and leisure occupations. The program has broad ranging goals:

- to minimise the effects of occupational disruption;
- to optimise the health-enhancing effects of engaging in meaningful and usual occupations;
- to maintain and increase patients' confidence, and self-efficacy, in occupational performance;

- to maintain patients' strength, endurance and cognitive capacities (that is, to build skill in components that underpin occupational performance); and ultimately,
- to reduce the phenomenon of deconditioning.

The program commenced in 2002 and runs six days per week. The current resources allocated to the program per week are eight h for occupational therapy, 14 h for physiotherapy, and 40 h for an allied health assistant, who works across both occupational therapy and physiotherapy. The program capacity is between 12- 16 patients and aims to offer daily therapy. This is in addition to the standard occupational therapy intervention received in the acute setting. The pilot program sustained ongoing funding after demonstrating effectiveness of desired outcomes, including: improved occupational and physical performance for participants of the program, improved patient flow of participants in the acute and subacute sectors and a reduced length of stay (LOS) of participants in the program.

The remainder of this paper is devoted to a discussion of the challenges that have been faced by the occupational therapists working within this program, and will also describe some potential solutions to these challenges. While there are many difficulties, this paper will discuss only three key issues related to patient expectations, the physical hospital environment, and hospital culture and work practices.

Challenges and Solutions

Patients' role expectations

Challenges

Older people may experience difficulty engaging in the program due to symptoms of illness/injury and feelings of being sick, tired, and/or in pain, as well as being unavailable to participate due to medical or surgical procedures. In addition, patients' expectations that they will be passive recipients, and/or that they need to 'rest' may result in reluctance to participate. In contrast to these expectations, in order to benefit from engaging in the FCP, patients must become *active participants*, who are motivated to engage in doing, in order to prevent the effects of deconditioning.

Solutions

The treating occupational therapists' experience has been that active participation is optimised when:

- Patients are involved in individual treatments as well as group treatments;
- Time is spent identifying the most meaningful occupations for the patient to participate in;
- Clear goals are set;
- Patients and their families or carer/s are educated about the detrimental effects of occupational disruption and ways of preventing it;
- Patient feedback about their participation in the program is sought and the program adapted to reflect this;
- Clear introduction and communication about the program is provided, which individualises the program goals for each patient; and,
- Brochures explaining the program are provided for the patient to read and consider.

Environmental barriers

Challenges

The environment of the hospital frequently does not provide appropriate opportunities for doing, since the hospital is designed for people to rest and recover *in bed*, rather than being actively involved in a variety of occupations. Therefore, there can be limited access to suitable chairs, portable oxygen tanks (that can allow a patient to leave a hospital ward) and limited access to personal items to allow the patient the opportunity to engage in even simple occupations of personal grooming and quiet occupations such as reading. Medical technology, such as intravenous poles and drainage tubes, can also be a physical barrier to engaging in usual occupations, as well as limited access to usual clothing and footwear. In addition, the clinical hospital environment can contribute to sensory and social deprivation (Inouye et al., 1999).

Solutions

It is acknowledged that while the physical environments of wards do not provide many opportunities for occupational engagement there are other spaces in the hospital that do support 'normal' occupational engagement. These areas include the public spaces of the hospital (cafeterias, shops), the occupational therapy department's kitchen and laundry, the hospital spirituality centre, and the public park nearby. In addition, everyday objects that enable doing, such as newspapers, have been used at low cost. Participants and their carer/s or families are also encouraged to bring in familiar objects (eg. books, puzzles, or craft materials), items to minimise sensory deprivation (eg. hearing aids, glasses, magnifying glass, usual gait aid), and clothing from home. In addition, an interest checklist has been modified to reflect the opportunities for doing within the limitations of the hospital environment.

Systems Issues

Challenges

A key concern in health-care provision is improving efficiency, and there is a strong drive towards reducing LOS and enabling access to hospital beds. Occupational therapy programs are competing for scarce resources. Financial providers of the program viewed favourable outcomes which can be shown to be linked to reduced LOS (enabling discharge and access), and thus the occupational therapy component of the program has needed to demonstrate effectiveness and strongly advocate for needed resources.

A further difficulty within the hospital system is the culture and work practices of staff, who are working from an acute and medical model of care. The ability to achieve consistency in the management of patients may then be compromised. For example, FCP interventions comprise only a small portion of the day, and input received by other staff may not have the same focus on prevention of deconditioning.

Solutions

Several actions have been undertaken to inform, educate and persuade hospital resource managers and other staff members of the value and importance of the program:

- Outcomes are regularly reviewed and reported to managers and key stakeholders;
- A SWOT analysis (which examines strengths, weaknesses, opportunities and threats) was undertaken to identify key issues and directions/ actions;

- There has been continuous evaluation and modification of the program, which has enabled for example, identification of target groups, clarification of referral processes and differentiation of the program from current services;
- The allied health assistant has implemented interventions (which are designed by the occupational therapist), since this is a more cost effective strategy than the occupational therapist spending time on implementation;
- Regular education is provided to medical, nursing and allied health staff through the use of flyers, posters, documentation in medical records, communication in team meetings and regular in-services; and,
- Frequent feedback is collected from participants and referrers to the program.

Conclusion

The occupational therapy contribution to the FCP aims to tackle the challenges of poor health and occupational disruption that can be associated with acute hospitalisation for older adults. This is achieved through encouraging and assisting patients to engage in a range of everyday occupations that are important and meaningful to them. The experiences of the occupational therapists involved in this program have convinced them that the program is able to meet its goals of improving health in older persons during hospitalisation, and as such this strategy may be useful for other occupational therapists working within institutional settings.

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