

Overcoming the gaps: Allied health in Post Acute Care

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Aim

Showcase the allied health roles within the
Loddon Mallee Post Acute Care program



Outline

- Background information
- Outline PAC Physiotherapy & Occupational Therapy roles
- Benefits of allied health intervention
- Practical applications & future directions
- Case scenario “Geoff”

Background Information

- Loddon Mallee PAC commenced in 1998
- Provision of short-term flexible care package to assist post discharge recovery and prevent hospital re-admission
- Loddon Mallee PAC unique in its inclusion of allied health positions
- AH geographic boundaries – Bendigo Shire



Background Information

- Occupational Therapy

Needs assessment in 2005 demonstrated:

- delays in post discharge intervention
- clients 'slipping through the gaps'

PAC OT started Dec 2005 (16 hrs/week)

- Physiotherapy

Position created March 2007 (8 hrs/week)



Case Scenario – “Geoff”

ED presentation:

Dizziness – likely Meniere’s disease

Worsening knee pain (R>L)

Right shoulder pain - xrays indicated OA

Past history:

Mild intellectual disability, short term memory loss, hypertension, anaemia, DVT

Case Scenario – “Geoff”

Social:

73 y.o. single, aged pensioner

Lives alone in Office of Housing unit

Nil support services or groups, not driving

Sister lives 80mins away, phones 2x weekly

Referral to PAC via ED Care Coordinator:

Request for support services and social outlets

Enter PAC OT...

- Initial assessment to identify occupational performance issues, including:
 - Reduced self-care
 - Difficulty rising from chairs/bed
 - Limited domestic performance
 - Poor sleep
 - Reduced community access
 - Nil identified leisure occupations

OT Role

- Service coordination:
 - Personal Care
 - General Home Care
 - Refer to PAC physiotherapist
- Further assessment – COPM goals:
 - Chair/bed transfers
 - Personal care
 - Social/leisure pursuits
 - Walking endurance

OT Role cont:

- Equipment prescription:
 - seating
 - bed pole
 - long handled aids
- Self-care retraining
- Liaise with Physio
- HACCC assessment
- Managing appts & community access
- Referral for outpatient OT & podiatrist f/up

Geoff and equipment



PAC Physiotherapist Role:

- Assessment of knee/shoulder pain and functional mobility
- Home exercise program and pain management strategies for knee pain
- Endurance walk program
- Retrain bed mobility and sit to stand
- Encouraged use of bridge chair
- Referral for outpatient PT follow-up

Geoff with mobility aid



Results

- Improved continuity of care between inpatient and community settings
- Improved multi-disciplinary care
- Comprehensive, objective assessment of post discharge service needs = more issues regularly identified than original reason for referral
- Feedback to referrers and GP, appropriate referral on to other agencies to enhance collaborative care

Practical Applications/Conclusions

- Organisations must continue efforts to stop people slipping through gaps in the health system.
- Acknowledge the confusion and challenges that occur for clients making the transition from hospital to home.
- Acknowledge rural AH workers and the need to have good knowledge of community resources etc. as this enhances continuity for clients and their families.

Practical Applications/Conclusions

- Community service agencies should aim to work within an active service model to accommodate the changing needs of clients and encourage maximum participation in daily occupations
- Reinforce benefits of multi-disciplinary input