Facing the Challenges of Distance Head on – Collaboration & Cooperation between Services

A Case Study Presentation

Presentation overview

- Site and Program background
- Client background
- Geography
- Problem and challenge
- Why was the challenge important?
- Intervention
- Collaboration
- Results
- Challenges, how were these overcome
- Learning for the future

Brightwater Oats St Rehab Program

- Brightwater Oats St is a 48 place slow stream residential rehabilitation program located in Perth, Western Australia.

- The program offers rehabilitation services to people who are aged between 18 and 65 with neurological disability resulting from an acquired brain injury (ABI)

Brightwater Oats St Rehab Program

- People who come to Oats St have sustained their injury in a variety of ways, including through trauma, stroke, hypoxia, substance abuse and infection.
- Some have already received traditional hospital-based rehabilitation while for others several years may have elapsed since their injury.
- Teamwork on all levels is intrinsic to the success of the Oats St model.

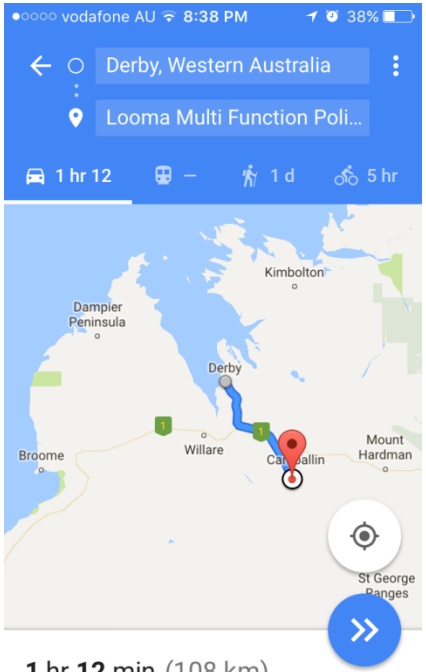
Client Background
J; events occurred

- 41 year old indigenous male, sustained ABI from a suspected assault in Oct 2014. Previous ABI from MVA 2007
- Right subdural hemorrhage, R MCA territory infarction, L subarachnoid hemorrhage, multiple facial fractures
- Initially admitted to Derby hospital, transferred to Royal Perth Hospital via RFDS
- R craniotomy and evacuation of SDH. Complicated with seizures post surgery
- Transferred to Fiona Stanley Hospital for rehab ; Dec 2014 (3 months)
- Discharged to Derby Nursing Home (Numbala Nanga); March 2015 (3.5 months)
- Transferred to KIFSA (Kimberley Individual and Family Support Association) purpose built home, Broome; June 2015 (YPINH)

Social History

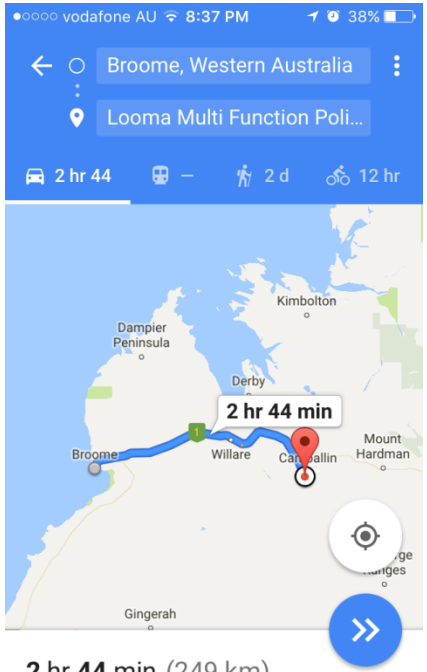
- Family
  - J lived in Looma all his life
  - He is from the Walmajarri language group whose country is located in the inland Kimberley region
  - 18 year old son, died in a MVA 4 years ago
  - Mum visits weekly from Looma
  - Sister lives in Broome but only visits when mum does
- Single
- Christian, enjoys going to church
- AFL – West Coast Eagles fan

Geography



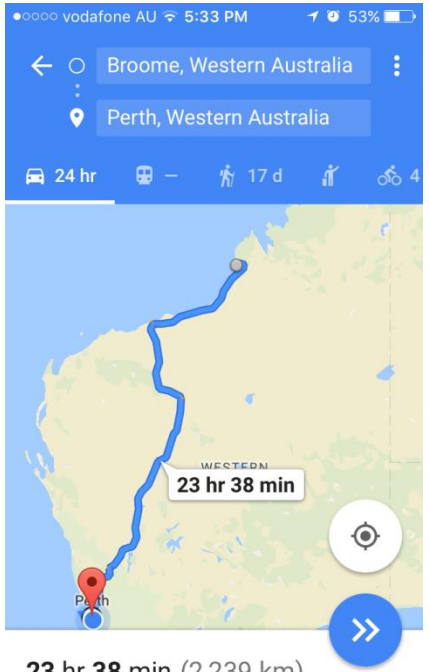
1 hr 12 min (108 km)

Fastest route



2 hr 44 min (249 km)

Fastest route



23 hr 38 min (2,239 km)

Fastest route

J's functional abilities (March 2015); on discharge from Fiona Stanley Hospital, Perth

- Bed mobility - practicing with x1 person assist
- Side lying to sitting over bed edge – x2 person assist
- Sitting balance and tolerance - supervision only for 15 minutes
- Practicing sit – stand and low pivot transfers daily - x2 person assist during physio
- Full hoist transfer in the ward
- ADL – totally dependent
- Discharged with lite writer for communication and an attendant propelled tilt in space wheelchair for mobility

J's functional abilities (April – June 2015) ; as per care plans of Derby Nursing Home

- Bed Mobility- totally dependent, required bed repositioning every 3-4 hours , no active participation in rolling, poor sitting balance
- ADL – showered in a bath trolley, fully dependent with all tasks
- Doubly incontinent – wears incontinent pads day and night
- Communication – nil verbal, thumbs up/ down, lite writer minimally
- Assessed once by the physio – therapy goals: sit out in w/c, engage with activities on site as much as possible

J's Functional Abilities (June 2015) ; on Assessment by BW physio while in KIFSA

- Transfers - 2 persons assist (full hoist transfer)
- Mobility – attendant propelled tilt in space wheelchair
- Incontinent - continence pads (day and night)
- Spent a lot of time in bed – fatigue and drowsy
- ADLs - totally dependent – shower commode
- Muscle atrophy
- Low mood
- Dysarthria , Lite writer to communicate
- Impacted negatively in his well being and QoL

Problem and challenge

- Residing in a home in regional WA
- Limited access to rehabilitation services, long wait list for hospital outpatient therapy
- Deconditioned while in Derby Nursing Home, Numbala Nanga
- From Derby, he was transferred to KIFSA in Broome – further away from home, isolated from family, affected mood
- KIFSA home – limited support staffing (some shift - only 1 staff) – further affecting J's mobility and continence

Why was the challenge important?

- Lack of resources in the region especially for the indigenous community

"Despite the high rates of risk factors for brain injury, the use of relevant health, rehabilitation and advocacy services is extremely low among Aboriginal and Torres Strait islander Australians"

(First People Disability Network, 2010)

- Long wait time for therapy due to shortage of staffing and high workload

"Accessing appropriate and timely primary care has been an issue for much of the remote Kimberley population for many years"

(Kimberley Primary Health Care Sustainability Study 2008 – 2030, Dec 2008)

Why was the challenge important ?

- Assessment BW – good rehab potential
- Potential improvements – mobility, continence, ADL participation- ultimately mood and Quality of Life
- J was a young man, early 40s
- Reduce complication of long term bed rest – pressure sores, contractures, fatigue, chest infections, muscle atrophy, general deconditioning
- Reduce risk of readmissions to hospital
- Reduce supports in the long term and the sustainability of existing funding provided
- Promote independence

Initial Collaboration

- Initial referral from KIFSA to BW Oats St, June 2015. J was identified by a BW staff via another project
- Assessment in Broome by BW – PT and Coordinator (OT) –travels - funded by BW fundraising
- DSC agree to hold placement in Broome
- Waitlisted – priority
- Arrangements for admission (Oct 2015 – March 2016)
  - Transport (flights) for J and equipment arranged
  - Accompanied by KIFSA support staff- accommodation and return flights
  - Funded by BW fundraising

Intervention

- Planned for a short term 4 months intensive rehab program at BW Oats St
- Important – ensure 24/7 functional rehab approach, emphasizes on practicing skills in everyday life
- Include training and close collaboration with KIFSA
- Rehab -based on Principles of Neuroplasticity – consistency, repetition, persistence
- Identified 2 main goals that were specific to J's long term permanent accommodation (KIFSA in Broome)
    1. Transfers – be able to transfer with one person assist
    2. Improve Continence – not to use pads in the day
- Goal Tree used for initial goal setting, monitor achievement and progress
- Duration of rehab - extended to 5 months

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BRIGHTwater
Services for Younger People

MY GOAL TREE

Client Reviews are your chance to set your goals with your team. These goals will guide you and the team in planning your rehabilitation

SURNAME:	URN:
GIVEN NAME: J	
DOB:	SEX: Male
Planning Start Date: 26/10/2015	Goal Tree / Plan

My ultimate goal is:

TO RETURN TO BROOME

My goals for the next 3 months are...

Goal 1	Goal 2	Goal 3	Goal 4	Goal 5
To transfer with the assistance of 1person during therapy	To attend soial and site activities	Return to Broome with rehab plans in place	Improve night time Continence	

These are the actions that will help me reach these goals...

To reach Goal 1 I will:	To reach Goal 2 I will:	To reach Goal 3 I will:	To reach Goal 4 I will:	To reach Goal 5 I will:
- Attend physio sessions 5 x per week. Trial pivot transfer Practise with standing hoist and educate staff	- staff to organise transportation to Koorong To visit Koorong bookshop	- pdate KIFSA regarding my progression CIC and KIFSA to organise KIFSA support workers for handover prior to discharge . Arrange for mum to come for a visit	Investigate options of assistance at nights	

Did I achieve my goals?

Remember that we are aiming for your goals and outcomes to be as 'expected'. This shows that the goal is 'just right' for you, that is, not too easy or too difficult

Did I achieve Goal 1	Did I achieve Goal 2	Did I achieve Goal 3	Did I achieve Goal 4	Did I achieve Goal 5
As expected / Goal fully achieve	As expected / Goal fully achieve	As expected / Goal fully achieve	As expected / Goal fully achieve	-

Meeting attended by:

Brightwater:

Completed by: _____ Designation: _____

Signature: _____ Date: _____

Client / Delegate:

Plan Complete Signature: _____ Date: _____

Plan Review Signature: _____ Date: _____

Therapy

- Daily PT / TA – transfer practice , sit to stand , exercise program, bed positioning
- PT/OT – standing using the grab rail to assist in showers, dressing, strengthening/ use of upper limb
- OT/SP – independence during breakfast preparation and self feeding
- RN – continence; asking to use toilet, night time Uridome
- Tasks are practiced with DSW and TA during daily
- Regular Support worker – familiar with J and vice versa
- Reviewed by visiting GP – decreased medications; increased alertness → participation in therapy

Further collaboration

- Ongoing feedback via phone and email to KIFSA Broome Coordinator
- Case Coordinator model - Community Integration Coordinator
- Tele conference between BW Oats St team and KIFSA team to update progress (at 3 month review)and plan for discharge (at end of 4 months)
- Planning with KIFSA Manager – identify equipment and funding options available, suitable environment , training of staff in Broome
- Collaboration with CAEP (Community Aids and Equipment Program) in Broome – purchase of the standing hoist, powered wheelchair

Discharge planning

- Accommodation and flights booked – Funded by fund raising philanthropy. Qantas – hoists availability
- Training and education – KIFSA Broome Coordinator was identified to attend a 2 day full hands-on training
- Training

- Buddy shifts with the DSWs for J's daily routine
- One on one training with each Allied Health Professional, including education and rationale therapy

- Care Plans – written with pictures and video care plans

Results

ADMISSION	DISCHARGE
Transfer : 2 persons assist (full hoist transfer)	1 person assist; standing hoist (Slide board with PT)
Sit – Stand (upright) : 3 persons at parallel bar	1 person assist with grab rail/ parallel bar
Attendant propelled tilt in space wheelchair	Powered WC trialed successfully indoors
Incontinent - continence pads (day and night)	Continent day time – uses jocks DAY, uridome NIGHT
Spent a lot of time in bed – fatigue and drowsy	Sustained attention on demanding activity half hour, 1 hour therapy sessions daily, memory - recall 3/3 items

Results

ADMISSION	DISCHARGE
ADLs –shower commode, totally dependent Starting to brush teeth and comb hair with encouragement, took a long time	Shower commode : Independent UB dressing, stand at rail LB dressing, Indpt – tooth brushing, comb hair. Supervision with occ. min assistance to shave
Communication – Severe dysarthria , Lite writer, thumbs up/down	Severe dysarthria, lite writer . Less gestures, single to few word sentence
Low Mood	Cheerful, smiling all the time
Impacted negatively in his well being and QoL	Improved independence

Challenges and how they were overcome

Challenges	Overcome
Socially isolated from supports at home (church and family)	Initiated phone calls to family , videos of family, visit by Pastor from Broome, visitation to the Christian bookshop in Perth
No family inclusion , affecting mood (mum visited weekly in Broome)	Part of the program, fundraising agreed on one visit with 3 nights stay by mum. Unsuccessful as mum was ill, sister unable to make it.
New environment	Consistent familiar Support Worker
Distance – poor phone service to Looma, mum's phone number changes weekly	Call Looma Community Centre to pass messages to mum
Financial	Brightwater fundraising

Challenges and how they were overcome – con't

Challenges	Overcome
Training of staff in Broome – no multiple staff buddy shift	Provided 2 days hands-on training to Broome Coordinator, Care Plans, Video care Plans
CAEP for equipment – long wait time in Broome (standing hoist, EWC)	Apply for CAEP in Broome and connecting with the OT while J was still in BW Oats St
Transport –logistics . Only 1 -2 flights per day with hoist available, Size limit for accompanying equipment	Early booking, timing of flight , continence, medical clearance
GP follow-up to monitor reduction in seizure meds (keppra). Risk of reinstating – limiting alertness and participation	Education – ABI , discharge summary to GP to wean off as recommended on discharge from FSH
Dental appointment	Unable to follow up after initial Ax. Waitlist In Broome Dental Health
Continuity, sustainability and progress	Education of importance for ongoing 24/7 inclusion as recommendation. Follow up with KIFSA Coordinator

Learning

- When discharging a client to the remote region –close collaboration with a metro service provider is important
- Close collaboration , improvement in a client's functional outcome → reducing long term cost for ongoing support
- Specific goals , specific time period → clear to client and staff
- Discharge destination and funding is confirmed → directs planning from Day 1 of admission
- Identified service provider – easier to identify possible challenges in advance e.g. Staffing, equipment, environment, goals realistic to long term accommodation

Learning – future improvements

- Early identification of other holistic needs (medical, dental) → follow up in metro
- Gap of timely rehab service provision in the region – Increase awareness of BW as a specialised neuro-rehab facility and possibility of short stint intensive rehab programs
- Collaboration with Primary health care providers – GPs, other service providers
- Early client identification

Summary

- Successful collaboration
- Possibility of a 2nd stint of short rehab – depending on funding
- When discharging a client back into the remote region, ongoing collaboration with service provider is integral
- For sustainability of gains achieved - training and education AND practicing during daily routine needs to be all part of therapy
- Goals need to be specific to the location of long term accommodation

‘Short term spending benefits long term savings’

Acknowledgement and Contacts

- Brightwater fundraising – RM Harken funding
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- DSC - Disability Services Commission, Western Australia
- Brightwater Oats St team
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- Adelene Yap

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