Evidence Brief: Community Rehabilitation Teams and Roles

Contents

Produced by the Knowledge Management team Evidence Briefs offer an overview of the published reports, research, and evidence on a workforce-related topic.

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There may have been an update to this Evidence Brief - to check you are reading the most current version please see the links below:

- Complete Evidence Brief list – link for Workforce, Training and Education staff
- Complete Evidence Brief list – link for External staff

Key publications – the big picture

A community rehabilitation and reablement model
Source: NHS England
Publication date: 15 September 2023
Good practice guidance for integrated care boards (commissioners and providers).
This new community rehabilitation and reablement model, published alongside the intermediate care framework, aims to ensure that the individual (and their families) is at the centre of discussions and that any transition points will be as seamless as possible.

Rehabilitation Support Worker Resources Pack
Source: NHS England London
Publication date: Updated June 2023
This resource pack is intended for London community stroke and neurorehabilitation services and commissioning bodies, as a resource for supporting with recruitment and management of rehabilitation support workers (RSW) within the workforce. It contains information and resources on the expectations and scope of RSW roles, signposting to other relevant information, policies and guidelines, and tools to assist with RSW management and recruitment.

NHS Long Term Workforce Plan
Source: NHS
Publication date: June 2023
The first comprehensive workforce plan for the NHS, putting staffing on a sustainable footing and improving patient care. It focuses on retaining existing talent and making the best use of new technology alongside the biggest recruitment drive in health service history.
See p. 31-32 "New and emerging roles are growing but not at a sufficient rate to fundamentally alter the overall shape of the workforce. In future, healthcare teams will continue to be led by clinical experts, but wider skills will be needed to help offer personalised, responsive care to patients, supporting them to be independent. This may involve digital monitoring of remote care and coaching to help patients manage their health, as well as expert practitioners to support rehabilitation, and drive care planning and decision-making. In addition to providing better care for patients, broader multiprofessional teams will mitigate some of the challenges in recruiting to traditional workforce roles."

Community Rehabilitation Toolkit
Source: NHS RightCare
Publication date: March 2020
This NHS RightCare system toolkit will support systems to understand the priorities in community rehabilitation care and the key actions to take. It provides opportunity to assess and benchmark current systems to find opportunities for improvement. It is produced with reference to an expert group of stakeholders and is supported by NICE. Wider consultation has taken place with patient representatives, clinicians, social care organisations, professional bodies and other key stakeholders (see acknowledgements page).
See “Match workforce to population needs”

Case Studies

Video case study: Joined up working with rehab at the centre
Source: Chartered Society of Physiotherapy
Publication date: 25 March 2024
A new model of intermediate care in Leeds is showing great results for patients, clinicians and the system.

Discharge to Assess - NELFT NHS Foundation Trust
Source: British Geriatrics Society
North East London Foundation Trust has an intensive multidisciplinary Community Rehabilitation Service across three London boroughs. The service operates seven days a week and manages people with complex and intensive rehabilitation needs. They support people to achieve personalised goals at home and identify other resources to help them continue their recovery once discharged from the team.

Impact of “enhanced” intermediate care located in a health & wellbeing hub at the integrated care organisation (ico) in Torbay and South Devon, UK
Author(s): Elston et al.
Source: International Journal of Integrated Care
Introduction: Torbay and South Devon NHS Foundation Trust, an Integrated Care Organisation, re-designed its Intermediate Care (IC) service to manage more complex, older patients in the community and facilitate earlier hospital discharge and reduce admissions from the community. The “Enhanced” IC service (EIC) employed GPs, pharmacists and the voluntary sector to work with social and community services (the traditional model) in locality ‘hubs’. It was assumed that EIC would deliver a more strengths-based, person-centred, coordinated care (PCCC) ‘closer to home’, whilst reducing system demand and costs. Methods: A mixed-methods case study, using embedded Researchers-in-Residence (RiR), compared the first established service (Coastal EIC) with four other localities, over time (natural experiment). Quantitative data: service input data (n=72); two ad-hoc validated surveys (n=672 and n=17) of PCCC in staff and patients; assessment of service use prevented (n=1001), including a ‘cost-offset’ analysis, calculating ‘notional’ annualised cost-saving; and routine data used to calculate rates in over 70 year-olds for referrals (acute and GP), bed-capacity, admissions and length of stay (LOS). Findings were co-produced with stakeholders to drive change and to explore explanations for differences in outcomes. Results: Service data showed GPs inputted into 36% of cases (not including GP contacts), pharmacists 15% and the voluntary sector 13%. Moderately high need service users reported fairly high levels of PCCC, with an average score of 66%. The PCCC practitioner survey (response rate 39%) showed higher levels of PCCC in 19/27 questions, compared to an Australian benchmark. PCCC was strongest in the domains of ‘treating people holistically’, ‘supporting activation’, ‘feeling joined-up’ and ‘involving the family’. ‘Care planning’, ‘single point of contact’ and ‘telling your story once’ required improvement. EIC prevented 1,940 incidences of service use (1.9 per referral). Most of this fell outside the ICO (Out of Hour GP and nursing services (45.1%), a GP telephone consultation (13.6%), Residential nursing (4.0%) and social services (3.2%)). Prevention of ICO service use equated to 2-3% of emergency attendances. The notional average cost saving was £149.17 per person, mostly due to secondary care avoided. Coastal EIC had persistently shorter LOS, lower bed-day and emergency attendance rates and more care at home than other localities, but fluctuations over time weaken attribution solely to EIC. Discussion: Coastal EIC was managing more complex patients in the community. Greater clinical and pharmaceutical input and personal information at the daily MDT, record sharing and pro-active links with GPs and the hospital, enabled more PCCC, impacting on LOS and demand. Conclusion: EIC has the potential to deliver better patient experience for complex, older

patients, whilst reducing demand and costs. Lessons learned: Implementing EIC consistently across localities presented challenges for leadership, GP engagement, record sharing, and links with community and acute services. RiRs can help facilitate relationships, learning and service development. Limitations: Implementing complex integrated interventions often precludes rigorous study designs. Although case studies and participatory research are prone to bias, they can provide rich insights and support change. Suggestions for future research: How can the RiR model support implementation of other complex integrated care initiatives?

Older People's Short Term Assessment Team

Source: HSC South Eastern Health and Social Care Trust
The Older People's Short Term Assessment Team provides Intermediate Care Services to older people, over 65 years old through a Single Point of Access.
A Multi-Disciplinary Team that includes, Social Work, Occupational Therapy, Physiotherapy and Intermediate Care Support Workers. The team use the principles of Intermediate Care with an aim to unlock potential and improve quality of life while building capacity to live well at home, for as long as possible.
When to call us?

- If you have no current Social Care services and require assistance, support and/or advice.
- If you wish to make a new referral for a relative/friend/neighbour who may require support and care.
- If you would like to speak to your current Social Care Key Worker & District Nurse.
-

Rehabilitation services during Covid

Source: Community Hospitals Association
The UK Community Hospital Association has published highlights on innovations in rehabilitation services developed during the pandemic. This ranged from digital innovation to reduce the need for home visits to rapid training, utilising the skills of physiotherapy, occupational therapy and nursing staff alongside a suite of supportive resources, which enabled clinicians to become available for redeployment to community wards.

Community Rehabilitation Case Study

Source: Chartered Society of Physiotherapy
My name is Sarah Daniel and I am the Director of MOTIONrehab Limited. MOTIONrehab have provided Neurological Rehabilitation across Yorkshire and Humberside for nearly 13 years. The delivery of our rehabilitation was predominately in the private sector, providing neurological physiotherapy in our clinic bases, people's homes or residential homes. In 2017, I was reflecting on the services we provided and considering whether we were maximising rehabilitation outcomes for our clients. At the time it was widely acknowledged that UK was experiencing a growing population of individuals with long-term rehabilitation needs as a consequence of stroke and other long-term conditions. Whilst I recognised that the NHS had a statutory obligation to meet the rehabilitation needs of the local population in line with The NHS Long Term Plan and other NICE guidelines and care pathways (e.g. Stroke Guidelines) the delivery model seemed less than optimal and there appeared to be an opportunity to improve rehabilitation services. I understood that the NHS had acknowledged that through Public Private Partnerships they could achieve the delivery of innovative, efficient, cost-effective treatment within modern facilities, whilst minimising their financial risk if they partnered with the private sector. With this in mind, I saw an opportunity to develop

MOTIONrehab and innovate the delivery of rehabilitation to the benefit of both private and NHS patients.

Long Covid Community Rehabilitation Service, Leeds
Source: BDA (The Association of UK Dieticians)
Publication date: July 2021
The Leeds Long Covid Community Rehabilitation Service, commissioned by NHS Leeds Clinical Commissioning Group (CCG), is a partnership between Leeds Community Healthcare NHS Trust and The Leeds Teaching Hospitals NHS Trust. It has been developed to help people in Leeds who are experiencing new, long-lasting problems 12 weeks or more after a confirmed or suspected COVID-19 infection which are significantly impacting how they are able to function in day-to-day life. The service is Allied Health Professional-led, with a team of physiotherapists, occupational therapists and dietitians, working with specialist consultants including a cardiologist and respiratory specialists, as well as a rehab consultant and temporary rehab registrar.

The Star for workforce redesign

More resources and tools are available in the **Community** section of the Star

Statistics

You can find relevant statistics on the Health and Care Statistics Landscape

National Data Programme

Workforce, Training and Education staff can look at the National Data Warehouse (NDL) SharePoint site to find out more about datasets and Tableau products.

Published Peer Reviewed Research

Community-based rehabilitation services implemented by multidisciplinary teams among adults with stroke: a scoping review with a focus on Chinese experience
Item Type: Journal Article
Authors: An, Zifen;Li, Ke;Yang, Xinyi;Ke, Jie;Xu, Yuying;Zhang, Xi;Meng, Xianmei;Luo, Xianwu and Yu, Liping
Publication Date: 2024
Journal: BMC Public Health 24(1), pp. 740
Abstract: BACKGROUND: Despite the growing interest in hospital rehabilitation services for communities, studies on existing community-based rehabilitation (CBR) services remain scarce owing to limitations in the development of community health services and regional cultural diversity. As a guaranteed measure for ensuring the quality of rehabilitation services and achieving the desired service outcomes, clear roles and responsibilities in multidisciplinary teams and effective service delivery are particularly important., OBJECTIVE: This scoping review aimed to determine the scope of community stroke rehabilitation programs involving existing multidisciplinary teams and to analyze the implementation content and implementers' functional roles to provide guidance for future CBR programs., METHODS: The scoping review design followed the methodology of the Joanna Briggs Institute and was based on the normative scoping review framework proposed by Arksey and O'Malley. The comprehensive CBR framework was

proposed by World Health Organization-guided data charting and analysis., RESULTS: Of the 22,849 identified citations, 74 studies were included, consisting of 6,809 patients with stroke and 49 primary caregivers, most of whom were from China. The most common working mode in CBR programs was a dual approach involving both healthcare professionals in medical institutions and community healthcare professionals. The number of programs in each discipline was in the following descending order: nursing, medical care, rehabilitation, psychology, nutrition, and public health. Among these, multidisciplinary teams comprising medical, nursing, and rehabilitation disciplines were the most common, with a total of 29 programs. Disciplinary members were mainly responsible for implementing their respective disciplinary content, with physicians providing guidance for the programs. More than 82.4% of the studies reported 2-4 intervention strategies. The intervention forms of rehabilitation content were the most diverse, whereas preventive interventions were more homogeneous than others. Physical function and socio-psychological measurements were the most commonly reported outcomes., CONCLUSION: CBR services implemented by multidisciplinary teams can effectively achieve functional and emotional improvement in patients with stroke, and nurses are the most involved in implementation, especially in community settings. The results further emphasize the importance of strengthening the exploration of nurses' maximum potential to implement CBR plans in future practice., TRIAL REGISTRATION: The registration information for this scoping review can be found at osf.io/pv7tg.

A pilot exploration of staff and service-user perceptions of a novel digital health technology (Virtual Engagement Rehabilitation Assistant) in complex inpatient rehabilitation

Item Type: Journal Article

Authors: Jarvis, Kathryn;Cook, Julie;Bavikatte, Ganesh;Branscombe, Nicola;Donovan, Steve;Haworth, Jo;Lawrence, Charlotte;Morland, Chris and Stockley, Rachel C.

Publication Date: 2024

Journal: Disability and Rehabilitation.Assistive Technology , pp. 1–11

Abstract: PURPOSE: Digital health technologies have the potential to advance rehabilitation. The Virtual Engagement Rehabilitation Assistant (VERA) is a digital technology, co-designed to increase service-user engagement and promote self-management. This qualitative study explored staff and service-user perceptions of implementing VERA on a UK complex inpatient rehabilitation ward., METHODS: Purposively sampled service-users were allocated to VERA for up to six weeks. The Non-adoption, Abandonment, Scale-up, Spread and Sustainability (NASSS) framework underpinned service-user post-intervention interviews and staff focus groups, and structured analysis of the data. Seven service-users were interviewed. Nine staff contributed to focus groups., RESULTS: A framework analysis identified themes (and subthemes) structured by the NASSS framework domains: 1. Nature of Clinical Condition, 2. Technology (Ease of Use, Holding Information/Resources in a single Digital Location, Appointments), 3. Value Proposition (Structuring Time, Feedback, Unexpected Benefits) 4. Adopters (Confidence in using Technology, Usefulness), 5. Wider Organisation. Ease of use and storage of key information in a single location were beneficial. Reliability, and provision of accurate and timely feedback to staff and service-users, were identified as essential., CONCLUSIONS: A blended approach is required to meet staff and service-user needs. The potential for VERA in a community

setting was identified and requires further investigation. Learning from VERA will support development of other digital technologies and their implementation.

Effective evaluations of community nursing on rehabilitation for stroke survivors: A meta-analysis Abstract only*
Item Type: Journal Article
Authors: Mi, Yuqing;Qu, Siyang;Huang, Jingwen;Yin, Yanling;Luo, Sheng;Li, Wei and Wang, Xiang
Publication Date: 2024
Journal: Geriatric Nursing (New York, N.Y.) 57, pp. 80–90
Abstract: BACKGROUND: Long-term rehabilitation of stroke survivors is often difficult and new tools to improve quality of life should be proposed. Community nursing can be a cost-effective tool to positively impact the lives of stroke survivors. This meta-analysis aimed to comprehensively evaluate the effects of community nursing on rehabilitation for stroke survivors., METHODS: The Cochrane Library, PubMed, Web of Science, CINAHL Plus, Embase, PEDro, China Knowledge Resource Integrated Database (CNKI), WANFANG, and WEIPU databases were comprehensively searched from their inception to April 18, 2023. The revised Cochrane risk-of-bias tool for RCTs(RoB 2 tool) was used to assess the quality of the included studies. Meta-analysis was conducted using the Stata 12.0 software package and Review Manager v5.3 software., RESULTS: A total of 25 randomized controlled trials with 2537 participants were included in the meta-analysis. Compared with the control group, community nursing combined with routine nursing had a significantly superior effect on the Barthel Index(BI), Fugl-Meyer(FMA), National Institutes of Health Stroke Scale(NIHSS), Self-rating Anxiety Scale(SAS), and Self-rating Depression Scale(SDS) scores for stroke survivors (BI: MD: 18.48, 95 % CI 16.87, 20.08], P 0.1, I2 < 50 %)., CONCLUSION: This meta-analysis demonstrated that community nursing combined with routine nursing might improve activities of daily living, motor function and nerve function, and relieve anxiety and depression in stroke survivors. Overall, community nursing had a significant effect on rehabilitation of stroke survivors. However, this study still has limitations such as the overestimation effects caused by the sample size and the risk of bias caused by interventions. Future research will attempt to overcome these limitations and comprehensively assess the effect of community nursing on the rehabilitation of stroke survivors. Copyright © 2024. Published by Elsevier Inc.

Therapists to Therapy Assistants: Experiences of Internationally Educated Physiotherapists and Occupational Therapists
Author(s): Kadakia et al.
Source: Canadian Journal of Occupational Therapy 27
Publication date: May 2024
Background: In Canada, internationally educated physiotherapists (IEPTs) and occupational therapists (IEOTs) may work as occupational/physical therapy assistants (OTAs/PTAs) while pursuing Canadian licensure. This experience presents personal and professional opportunities and challenges. Purpose: We explored a) the barriers and facilitators experienced by IEPTs and IEOTs working as OTAs/PTAs while pursuing licensure in Canada and b) how might their professional identity changes during this period. Methods: In this cross-sectional qualitative study, we sampled IEPTs and IEOTs working as assistants using online focus groups. Reflexive thematic analysis of data was used to generate themes. Findings: Fourteen IEPTs or IEOTs participated reporting barriers including financial impacts while working as an OTA/PTA, discrimination, and challenges completing licensing exams. Facilitators while working as OTA/PTAs included social support, acculturation with Canadian systems, and career opportunities. Changes to professional identity encompassed accepting a new identity, reclaiming their old identity, or having a strong sense of identity within a healthcare profession.

Participants advocated for bridging programs and modifications for examination processes for IEPTs and IEOTs to improve their experiences while pursuing licensure in Canada. Conclusion: Increased advocacy is needed to address the current experiences of IEPTs and IEOTs working as OTA/PTAs after migration.

Models of Governance of Disability Therapy Support Workers in Rural and Remote Settings: A Systematic Scoping Review
Item Type: Journal Article
Authors: Moran, Anna;Bulkeley, Kim;Johnsson, Genevieve;Tam, Elaine and Maloney, Catherine
Publication Date: 2024
Journal: International Journal of Environmental Research and Public Health 21(6)
Abstract: The National Disability Insurance Scheme (NDIS) ushered in a transformative era in disability services in Australia, requiring new workforce models to meet evolving participant needs. Therapy Assistants are utilised to increase the capacity of therapy services in areas of workforce shortage. The governance arrangements required to support this emergent workforce have received limited attention in the literature. This review examined the key components and contextual factors of governance in rural settings, specifically focusing on therapy support workers under the guidance of allied health professionals in rural and remote areas. Guided by the social model of disability and the International Classification of Functioning, Disability and Health, a realist perspective was used to analyse 26 papers (after deduplication), mostly Australian and qualitative, with an emphasis on staff capabilities, training, and credentialling. Success measures were often vaguely defined, with most papers focusing on staff improvement and few focusing on client or organisational improvement. Consistent staffing, role clarity, community collaboration, and supportive leadership were identified as enabling contexts for successful governance of disability therapy support workers in rural areas. Investment in capability (soft skills) development, tailored training, competency assessment, credentialling, and supervision were identified as key activities that, when coupled with the identified enabling contexts, were likely to influence staff, client and organisational outcomes. Further research is warranted to explore long-term impacts of governance arrangements, educational program accountability, and activities targeted at enhancing staff capabilities.

Healthcare professionals' experiences of delivering a stroke Early Supported Discharge service - An example from Ireland
Item Type: Journal Article
Authors: O Connor, Elaine;Dolan, Eamon;Horgan, Frances;Galvin, Rose and Robinson, Katie
Publication Date: 2024
Journal: Clinical Rehabilitation 38(3), pp. 414–426
Abstract: OBJECTIVE: To explore healthcare professionals' experiences of the development and delivery of Early Supported Discharge for people after stroke, including experiences of the COVID-19 pandemic., DESIGN: Qualitative descriptive study using one-to-one semi-structured interviews. Data were analysed using reflexive thematic analysis., SETTING: Nine Early Supported Discharge service sites in Ireland., PARTICIPANTS: Purposive sampling identified 16 healthcare professionals., RESULTS: Five key themes were identified (1) Un-coordinated development of services, (2) Staff shortages limit the potential of Early Supported Discharge, (3) Limited utilisation of telerehabilitation post COVID-19 pandemic, (4) Families need information and support, and (5) Early Supported Discharge involves collaboration with people after stroke and their families., CONCLUSIONS: Findings highlight how Early Supported Discharge services adapted during the COVID-19 pandemic and how gaps in the service impacts on service delivery. Practice implications include the need to address staff recruitment and

retention issues to prevent service shortages and ensure consistent access to psychology services. Early Supported Discharge services should continue to work closely with families and address their information and support needs. Future research on how telerehabilitation can optimally be deployed and the impact of therapy assistants in Early Supported Discharge is needed.

Evidence reviews for early supported discharge: Stroke rehabilitation in adults (update): Evidence review A1
Item Type: Journal Article
Publication Date: 2023
Abstract: Early supported discharge (ESD) is a recognised approach/intervention to provide ongoing rehabilitation to stroke survivors in their own homes instead of remaining in hospital. The rehabilitation/recovery program is delivered by specialist members of the multidisciplinary team (MDT) in the community. The key advantage of ESD is that stroke survivors can be discharged from hospital sooner and supported to continue recovering at home. Most patients prefer to get better/ recover at home, and the ESD model offers the possibility. This community rehabilitation/ recovery program is delivered by specialist members of the MDT such as physiotherapists, occupational therapists, speech and language therapists, and rehabilitation assistants. The amount of therapy provided at home should be equal to therapy provided in hospital. Some hospitalised stroke survivors will be eligible for ESD depending on the amount of therapy they require, their current physical/ functional abilities, the amount/ level of support they have at home, and the practicality of delivering therapy in patients' homes. The decision to refer some stroke patients to ESD is made by the hospital MDT. This decision should be discussed with and agreed by patients and their family members or carers before patients are discharged from hospital. There is robust published evidence that ESD results in stroke patients spending less time in hospital, and that their recovery is comparable to those who remained in hospital. Provision of ESD varies around the UK, with some regions having longer waiting times for the community MDT to start therapy at home than others. This review is split into four documents: 1.1 early supported discharge A introduction and quantitative. 1.1 early supported discharge B qualitative, mixed methods and committee discussion. 1.1 early supported discharge C appendix A to E (protocol, study selection diagrams, quantitative and qualitative evidence tables). 1.1 early supported discharge D appendix F to O (results, forest plots, GRADE and GRADE CerQUAL tables, economic evidence appendices, excluded studies, research recommendations). Copyright © NICE 2023.

How do stroke early supported discharge services achieve intensive and responsive service provision? Findings from a realist evaluation study (WISE)
Authors: Chouliara, Niki;Cameron, Trudi;Byrne, Adrian;Lewis, Sarah;Langhorne, Peter;Robinson, Thompson;Waring, Justin;Walker, Marion and Fisher, Rebecca
Publication Date: 2023
Journal: BMC Health Services Research 23(1), pp. 299
Abstract: BACKGROUND: Stroke Early Supported Discharge (ESD) involves provision of responsive and intensive rehabilitation to stroke survivors at home and it is recommended as part of the stroke care pathway. Core components have been identified to guide the delivery of evidence-based ESD, however, service provision in England is of variable quality. The study sought to understand how and in what conditions the adoption of these components drives the delivery of responsive and intensive ESD services in real world settings., METHODS: This qualitative study was part of a wider multimethod realist evaluation project (WISE) conducted to inform large-scale ESD implementation. Overarching programme theories and related context-mechanism-outcome configurations were used as a

framework to guide data collection and analysis. Six case study sites were purposively selected; interviews and focus groups with ESD staff members were conducted and analysed iteratively., RESULTS: We interviewed 117 ESD staff members including clinicians and service managers. Staff highlighted the role of certain core components including eligibility criteria, capacity, team composition and multidisciplinary team (MDT) coordination in achieving responsive and intensive ESD. Regardless of the geographical setting, adhering to evidence-based selection criteria, promoting an interdisciplinary skillset and supporting the role of rehabilitation assistants, allowed teams to manage capacity issues and maximise therapy time. Gaps in the stroke care pathway, however, meant that teams had to problem solve beyond their remit to cater for the complex needs of patients with severe disabilities. Adjusting MDT structures and processes was seen as key in addressing challenges posed by travel times and rural geography., CONCLUSIONS: Despite variations in the wider service model of operation and geographical location, the adoption of core components of ESD helped teams manage the pressures and deliver services that met evidence-based standards. Findings point to a well-recognised gap in service provision in England for stroke survivors who do not meet the ESD criteria and emphasise the need for a more integrated and comprehensive stroke service provision. Transferable lessons could be drawn to inform improvement interventions aimed at promoting evidence-based service delivery in different settings., TRIAL REGISTRATION: ISRCTN: 15,568,163, registration date: 26 October 2018. Copyright © 2023. The Author(s).

Individualized home-based rehabilitation after stroke in France: a pragmatic study of a community stroke rehabilitation team
Authors: Daviet, Jean-Christophe;Compagnat, Maxence;Bonne, Guillaume;Maud, Laurene;Bernikier, David and Salle, Jean-Yves
Publication Date: 2023
Journal: The Canadian Journal of Neurological Sciences.Le Journal Canadien Des Sciences Neurologiques 50(3), pp. 405–410
Abstract: BACKGROUND: Community stroke rehabilitation teams (CSRT) provide an individualized home-based rehabilitation service to patients recovering from stroke., OBJECTIVE: To examine whether there is an improvement in the social participation of patients who received a rehabilitation program provided by CSRT. The secondary objectives were to show if there is an improvement in the patients' quality of life and a reduction in the caregiver burden., METHODS: Retrospective cohort study, pragmatic in real-care conditions. The rehabilitation program delivered by the CSRT was adapted to the needs of the patients and caregivers. The outcome questionnaires included: the Frenchay Activity Index (FAI), the Minizarit, the EuroQol EQ5D, and the Barthel Index. The primary outcome measure was the FAI., RESULTS: We included 206 patients followed by the CSRT over the 2018-2020 study period, for whom the primary endpoint was present. The mean age was 66.3 +/- 12.7 years, the post-stroke delay was 16.4 +/- 32.7 months, and the Barthel index was 66.42 +/- 12.6. The duration of the rehabilitation program was on average 162 +/- 109 days. We observed a significant improvement in the FAI, from 12.9 +/- 10.4 to 17.85 +/- 12.4 ($p < 0.00001$); in the EuroQol, from 57.51 +/- 19.96 to 66.36 +/- 18.87 ($p < 0.00001$); in the mini-Zarit, from 2.49 +/- 1.75 to 2.06 +/- 1.67 ($p = 0.0002$); and in the Barthel index, from 66.42 +/- 12.67 to 84.81 +/- 23.70 ($p < 0.001$)., CONCLUSION: Patients who received a rehabilitation program by the CSRT have an improvement in their social participation, and their informal caregivers have a reduction in their burden.

What is important in supporting self-management in community stroke rehabilitation? A Q methodology study
Item Type: Journal Article
Authors: Duncan Millar, Julie;Mason, Helen and Kidd, Lisa
Publication Date: 2023
Journal: Disability and Rehabilitation 45(14), pp. 2307–2315
Abstract: PURPOSE: Supported self-management (SSM) is an important part of adapting to life after stroke however it is a complex concept. It is unclear what SSM in stroke consists of or how stroke survivors, families, and clinicians can most effectively work together to support person-centred self-management. In this study, we aimed to explore what was most important in making SSM work in community stroke rehabilitation., METHODS: We conducted a Q-methodology study with stroke survivors (n = 20), community-based stroke clinicians (n = 20), and team managers (n = 8) across four health boards in Scotland, United Kingdom. Participants ranked 32 statements according to their importance in making SSM work. Factor analysis was used to identify shared viewpoints., RESULTS: We identified four viewpoints: (i) A person-centred approach to build self-confidence and self-worth; (ii) Feeling heard, understood, and supported by everybody; (iii) Preparation of appropriate resources; and (iv) Right thing, right place, right time for the individual. Important across all viewpoints were: a trusting supportive relationship; working in partnership; focusing on meaningful goals; and building self-confidence., CONCLUSIONS: Differing views exist on what is most important in SSM. These views could be used to inform quality improvement strategies to support the delivery of SSM that considers the preferences of stroke survivors. IMPLICATIONS FOR REHABILITATIONClinicians should be aware of their own viewpoint of supported self-management and consider how their perspective may differ from stroke survivors' and colleagues' perspectives of what's important to support self-management.Working in partnership with stroke survivors plus developing a trusting and supportive relationship with them are core components of supporting self-management in the longer term after stroke.Building a sense of self-worth and self-confidence, a focus on meaningful goals, training and support for staff, and tailoring support to people's needs at the right time are important considerations for supporting longer-term engagement in self-management.

Identifying the Active Ingredients of a Computerized Speech and Language Therapy Intervention for Poststroke Aphasia: Multiple Methods Investigation Alongside a Randomized Controlled Trial
Item Type: Journal Article
Authors: Harrison, Madeleine;Palmer, Rebecca and Cooper, Cindy
Publication Date: 2023
Journal: JMIR Rehabilitation and Assistive Technologies 10, pp. e47542
Abstract: BACKGROUND: Aphasia is a communication disorder affecting more than one-third of stroke survivors. Computerized Speech and Language Therapy (CSLT) is a complex intervention requiring computer software, speech and language therapists, volunteers, or therapy assistants, as well as self-managed practice from the person with aphasia. CSLT was found to improve word finding, a common symptom of aphasia, in a multicenter randomized controlled trial (Clinical and Cost Effectiveness of Computer Treatment for Aphasia Post Stroke Big CACTUS])., OBJECTIVE: This study provides a detailed description of the CSLT intervention delivered in the Big CACTUS trial and identified the active ingredients of the intervention directly associated with improved word finding for people with aphasia., METHODS: We conducted a multiple methods study within the context of a randomized controlled trial. In study 1, qualitative interviews explored key informants' understanding of the CSLT intervention, how the components interacted, and how they could be measured. Qualitative data

were transcribed verbatim and analyzed thematically. Qualitative findings informed the process measures collected as part of a process evaluation of the CSLT intervention delivered in the Big CACTUS trial. In study 2, quantitative analyses explored the relationship between intervention process measures (length of computer therapy access; therapists' knowledge of CSLT; degree of rationale for CSLT tailoring; and time spent using the software to practice cued confrontation naming, noncued naming, and using words in functional sentences) and change in word-finding ability over a 6-month intervention period., RESULTS: Qualitative interviews were conducted with 7 CSLT approach experts. Thematic analysis identified four overarching components of the CSLT approach: (1) the StepByStep software (version 5; Steps Consulting Ltd), (2) therapy setup: tailoring and personalizing, (3) regular independent practice, and (4) support and monitoring. Quantitative analyses included process and outcome data from 83 participants randomized to the intervention arm of the Big CACTUS trial. The process measures found to be directly associated with improved word-finding ability were therapists providing a thorough rationale for tailoring the computerized therapy exercises and the amount of time the person with aphasia spent using the computer software to practice using words in functional sentences., CONCLUSIONS: The qualitative exploration of the CSLT approach provided a detailed description of the components, theories, and mechanisms underpinning the intervention and facilitated the identification of process measures to be collected in the Big CACTUS trial. Quantitative analysis furthered our understanding of which components of the intervention are associated with clinical improvement. To optimize the benefits of using the CSLT approach for word finding, therapists are advised to pay particular attention to the active ingredients of the intervention: tailoring the therapy exercises based on the individual's specific language difficulties and encouraging people with aphasia to practice the exercises focused on saying words in functional sentences., TRIAL REGISTRATION: ISRCTN Registry ISRCTN68798818; https://www.isrctn.com/ISRCTN68798818. C opyright ©Madeleine Harrison, Rebecca Palmer, Cindy Cooper. Originally published in JMIR Rehabilitation and Assistive Technology (https://rehab.jmir.org), 05.12.2023.

Healthcare Professionals' Experiences with Functional Independence Measure (FIM) as a Structured Framework for Interprofessional Team Meetings in Danish Stroke Rehabilitation: A Qualitative Cross-Sectoral Collaborative Study Full text available with NHS OpenAthens account*
Item Type: Journal Article
Authors: Lauesen, J. D.;Larsen, K.;Lykke, J. L.;Christensen, M.;Arens, C. H.;Bigum, H. and Varalta, V.
Publication Date: 2023
Journal: Rehabilitation Research and Practice 2023 doi, pp. 10.1155/2023/6660296
Abstract: Purpose. An ethnographic and phenomenological mapping of the experiences of healthcare professionals with the functional independence measure (FIM) in stroke rehabilitation. Methods. This is a cross-sectoral qualitative study with triangulation of data from two focus group interviews, 15 individual interviews, and 11 participant observations of FIM assessments performed by six different healthcare professions in interprofessional teams. FIM assessments were performed at hospital and in a community rehabilitation centre as interprofessional meetings with a local facilitator certified in FIM. Results. Three overarching themes, learning space, improved interprofessional collaboration, and transferability, emerged from the data. The use of FIM within the provided structures established an environment that allowed the various healthcare professionals (HCP) to learn with, about, and from each other. This is perceived as promoting interprofessional collaboration and enhancing patient-specific knowledge within the interprofessional team. The established patient-specific

knowledge is specific to the individual team and is difficult to transfer intraorganisationally and across sectors. Conclusion. FIM was a catalyst for improved interprofessional knowledge transfer and interprofessional collaboration within the individual teams, but intraorganisational and cross-sectoral dissemination of patient-specific knowledge was limited.

Outcomes from a collaborative project developing and evaluating a community rehabilitation worker program for Northwestern Ontario First Nations
Item Type: Journal Article
Authors: Moller, Helle;Baxter, Robert;Denton, Alison;French, Esme;Hill, Mary Ellen;Klarner, Taryn;Nothing, Garth W.;Quequish, Marlene;Rae, Joan;Reinikka, Kirsti;Strickland, Shane and Taylor, Denise
Publication Date: 2023
Journal: Rural and Remote Health 23(3), pp. 7809
Abstract: INTRODUCTION: Major inequities exist in levels of health and wellbeing, availability, and access to healthcare services between seniors of Indigenous and non-Indigenous background in Ontario. First Nations elders are 45-55% more frail than the average senior in Ontario. Additionally, needed rehabilitation services are not easily accessible or available in the first language of most First Nations elders within their home communities. A literature review demonstrated community-based rehabilitation assistant models had been successfully developed and implemented in regions facing similar equity and access challenges. Building on these findings, a needs assessment was conducted to capture unique needs and requirements in Northwestern Ontario relating to rehabilitation among First Nations elders., METHODS: The needs assessment resulted in four First Nations, three Indigenous health organizations, three rehabilitation health organizations, and two academic institutions iteratively developing and evaluating curriculum for a Community Rehabilitation Worker (CRW) program in treaty territories 5, 9, and Robinson-Superior. The goal of the program is to train local CRWs, familiar with local languages and cultures, to provide rehabilitative services that support ageing in place, health, wellbeing, and quality of life for First Nations elders. The study employed a community participatory action research approach aligning with the OCAP (Ownership, Control, Access, and Possession) framework for working with Indigenous populations. Seventeen community partners were active participants in the program development, evaluation, and adaptation of the CRW curriculum. Feedback was received through advisory committee meetings, surveys, and individual and group interviews., RESULTS: All 101 participants agreed, across all curriculum modules, that (1) the time allotment was realistic; (2) instructional materials, activities, and resources were appropriate and easy to understand; (3) evaluation activities accurately measured learning; and (4) participants identifying as Indigenous felt that Indigenous culture was adequately reflected. The qualitative findings highlighted the importance of incorporating culture, spirituality, traditions, local language use, and reintegration of First Nations elders into traditional activities and community activities for both the CRW curriculum and rehabilitation efforts. The need for locally available First Nations, elder-focused mental health support, transportation options, and gathering spaces such as those commonly seen in urban areas was also highlighted., CONCLUSION: The process of iteratively developing and evaluating a CRW program resulted in a Northwestern Ontario college welcoming the first cohort of students to the CRW program in March 2022. The program is co-facilitated with a First Nations Elder and includes components of local culture, language, and the reintegration of First Nations elders into community as part of the rehabilitation efforts. In addition, to appropriately support the quality of life, health, and wellbeing of First Nations elders, the project team called upon provincial and federal governments to work with First Nations to make available dedicated funding to address inequities in

resources available to First Nations elders in Northwestern Ontario urban and First Nations remote communities. This included elder-focused transportation options, mental health services, and gathering places. The program implementation will be evaluated with the first cohort of CRWs for further adaptations considering potential scale and spread. As such, the project and findings may also represent a resource for others wishing to pursue similar development using participatory approaches in rural and remote communities both nationally and internationally.

Promoting Activity, Independence, and Stability in Early Dementia and mild cognitive impairment (PrAISED): randomised controlled trial
Author(s): Harwood et al.
Source: BMJ
Publication date: August 2023
Objective To determine the effectiveness of an exercise and functional activity therapy intervention in adults with early dementia or mild cognitive impairment compared with usual care. Design Randomised controlled trial. Setting Participants' homes and communities at five sites in the United Kingdom. Participants 365 adults with early dementia or mild cognitive impairment who were living at home, and family members or carers. Intervention The intervention, Promoting activity, Independence, and Stability in Early Dementia and mild cognitive impairment (PrAISED), was a specially designed, dementia specific, rehabilitation programme focusing on strength, balance, physical activity, and performance of activities of daily living, which was tailored and progressive and addressed risk and the psychological needs of people with dementia. Up to 50 therapy sessions were provided over 12 months. The control group received usual care plus a falls risk assessment. Procedures were adapted during the covid-19 pandemic. Main outcome measures The primary outcome was score on the carer (informant) reported disability assessment for dementia scale 12 months after randomisation. Secondary outcomes were self-reported activities of daily living, physical activity, quality of life, balance, functional mobility, fear of falling, frailty, cognition, mood, carer strain, service use at 12 months, and falls between months 4 and 15. Results 365 patient participants were randomised, 183 to intervention and 182 to control. The median age of participants was 80 years (range 65-95), median Montreal cognitive assessment score was 20 out of 30 (range 13-26), and 58% (n=210) were men. Intervention participants received a median of 31 therapy sessions (interquartile range 22-40) and reported completing a mean 121 minutes of PrAISED exercise each week. Primary outcome data were available for 149 intervention and 141 control participants. Scores on the disability assessment for dementia scale did not differ between groups: adjusted mean difference −1.3, 95% confidence interval −5.2 to 2.6; Cohen's d effect size −0.06, 95% confidence interval −0.26 to 0.15; P=0.51). Upper 95% confidence intervals excluded small to moderate effects on any of the range of outcome measures. Between months 4 and 15 the intervention group experienced 79 falls and the control group 200 falls (adjusted incidence rate ratio 0.78, 95% confidence interval 0.5 to 1.3; P=0.3). Conclusion The intensive PrAISED programme of exercise and functional activity training did not improve activities of daily living, physical activity, or quality of life; reduce falls; or improve any other secondary health status outcomes, despite good uptake. Future research should consider alternative approaches to maintaining ability and wellbeing in people with dementia.

Use of Adapted Dance to Intensify Subacute Rehabilitation Post-Stroke: A Qualitative Study on the Participation Experience and Active Participation Time Abstract only*
Item Type: Journal Article
Authors: Beaudry, Lucie;Rochette, Annie and Fortin, Sylvie
Publication Date: 2022
Journal: Alternative Therapies in Health and Medicine 28(7), pp.

40–51
Abstract: Background: Strategies are still needed to intensify stroke rehabilitation. As an alternative therapy, dance warrants examination since its multimodal nature appears to offer an enjoyable means of engaging in a rehabilitation activity., Objectives: (1) To describe the participation experience in an adapted-dance group intervention, and (2) to study the patients' active participation time., Methods: In this embedded single-case study, the experience of participating patients, relatives and rehabilitation assistants was examined through semi-structured interviews. The verbatim transcripts underwent thematic analysis (qualitative method), while the patients' active participation time was examined through audiovisual recordings analyzed by type and length of engagement time (quasi-qualitative method)., Setting: The study was conducted in the neurology department of a rehabilitation hospital., Participants: The study included patients doing intensive functional rehabilitation post-stroke (<=25 days) (n = 6), relatives (n=4) and rehabilitation assistants (n = 4). Patients were recruited irrespective of their neurologic impairments. Their mean age was 71.0 years +/- 9.9 years (range 59 to 86 years)., Intervention: An adapted-dance group intervention ranging from moderate to somewhat hard/hard intensity was added to their rehabilitation program in the form of biweekly sessions of 55 minutes each, for up to 10 weeks. Carried out mainly on chairs, the intervention borrowed from dance approaches, rehabilitation practices, and movement-based educational approaches., Results: Observed adherence reached 82%. The participation experience involved 3 types of participation incentives (what motivated, fostered and facilitated their participation) and 4 types of perceived effort (unconscious, self-regulated, feasible and appropriate) conducive to participation. Mean motor engagement time of 50 minutes 4 seconds/session +/- 2.53 minutes was observed in patients., Conclusion: The use of an adapted-dance group intervention can contribute to the intensification of stroke rehabilitation and have a positive impact on motivation and perceived effort.

Evaluating the impact of a training program to support transitioning from the hospital to the community for people after stroke: a community case study
Item Type: Journal Article
Authors: Lui, Michelle;McKellar, Katherine;Cooper, Shari;Eng, Janice J. and Bird, Marie-Louise
Publication Date: 2022
Journal: BMC Health Services Research 22(1), pp. 30
Abstract: BACKGROUND: The transitions in care along the stroke recovery path are challenging, particularly in finding mechanisms to continue one's recovery once at home. We aim to evaluate the impact of training physiotherapists and fitness instructors from one regional community together to deliver an evidence-based group exercise program starting in the hospital and transitioning to the community using an implementation approach., METHODS: The evidenced based exercise program Fitness and Mobility Exercise (FAME) for stroke was chosen as the intervention. Data from interviews with stakeholders (community centre and health authority hospital staff including a physiotherapy navigator) was transcribed and themes evaluated using the RE-AIM (Reach, Efficacy, Adoption, Implementation, Maintenance) framework. These data were supplemented by information collected as a quality assurance project within the health authority., RESULTS: Two programs were established; one in the community centre (run over 15 months by fitness instructors) and one in the regional hospital (run over 12 months by a rehabilitation assistant under the direction from a physiotherapist). Transitions in care were facilitated by implementing the same evidence-based group exercise class in both the hospital and community setting, so people living with stroke could seamlessly move from one to another. An existing physiotherapist navigator service also was valued as a support

for the transitions between the two centres for people with stroke. The hospital group accessed group-based physiotherapy service on average 31 days earlier than they were able to in a one-to-one format., CONCLUSIONS: This case study described the implementation of the Fitness and Mobility Exercise (FAME) program in one community and the use of a physiotherapist navigator to assist transition between them. After a community training workshop, FAME programs were established within the health authority and the community centre. FAME program participants within the health authority benefited from reduced wait times to access hospital outpatient physiotherapy service. Improvements in function were measured in and reported by the people after stroke attending either the health authority or community centre FAME groups. Copyright © 2022. The Author(s).

Therapy Assistant Staffing and Patient Quality Outcomes in Skilled Nursing Facilities Abstract only*
Item Type: Journal Article
Authors: Prusynski, Rachel A.;Frogner, Bianca K.;Skillman, Susan M.;Dahal, Arati and Mroz, Tracy M.
Publication Date: 2022
Journal: Journal of Applied Gerontology : The Official Journal of the Southern Gerontological Society 41(2), pp. 352–362
Abstract: Therapy staffing declined in response to Medicare payment policy that removes incentives for intensive physical and occupational therapy in skilled nursing facilities, with therapy assistant staffing more impacted than therapist staffing. However, it is unknown whether therapy assistant staffing is associated with patient outcomes. Using 2017 national data, we examined associations between therapy assistant staffing and three outcomes: patient functional improvement, community discharge, and hospital readmissions, controlling for therapy intensity and facility characteristics. Assistant staffing was not associated with functional improvement. Compared with employing no assistants, staffing 25% to 75% occupational therapy assistants and 25% to 50% physical therapist assistants were associated with more community discharges. Higher occupational therapy assistant staffing was associated with higher readmissions. Higher intensity physical therapy was associated with better quality across outcomes. Skilled nursing facilities seeking to maximize profit while maintaining quality may be successful by choosing to employ more physical therapy assistants rather than sacrificing physical therapy intensity.

Exploring the delivery of community rehabilitation services for older people in an urban Canadian setting: Perspectives of service providers, managers, and health system administrators
Author(s): Leclair et al.
Source: Health & Social Care in the Community 30(5)
Publication date: September 2022
As the global population of older people increases, policies aimed at improving health care delivery for older people often include supports for ageing in place. Living in the community not only reduces institutionalisation but also improves quality of life and reduces health care costs. For older people, community rehabilitation offers the opportunity to preserve and maximise function while maintaining the ability to live in the community. However, limited research examines the delivery, coordination and integration of community rehabilitation services in health systems. Our case study explored the perspectives of service providers, managers and health system administrators on the strengths, limitations and gaps in community rehabilitation for older people in one Canadian urban health region. Using interpretive description and thematic analysis, we analysed interview data from: 16 service providers, eight managers and five health system administrators. Three themes were identified: (a) Limited Access to Programs and Services; (b) Need to Emphasise Promoting, Maintaining and Restoring Function; and (c) Lack of Flow Across the System. Participants highlighted that

restrictive eligibility criteria limited access to services. Services were organised around health conditions that did not address the needs of older people. Long waitlists meant that services were delayed. Transportation costs limited participation of individuals from lower socioeconomic status (SES). Age restrictions did not reflect differences in the ageing process and the health inequities individuals from lower SES groups experienced. There was a lack of emphasis in community rehabilitation programs on maintaining or restoring function in older people, which is the primary focus of rehabilitation. Furthermore, key stakeholders stressed the need for strengthening the integration of service delivery across the continuum of care. The findings underscore the need to develop a conceptual framework for community rehabilitation to promote greater system integration, access and availability of services and to optimise functional outcomes for older people.

Transitions from healthcare to self-care: a qualitative study of falls service practitioners' views on self-management.
Item Type: Journal Article
Authors: Killingback, Clare;Thompson, Mark A.;Chipperfield, Sarah;Clark, Carol and Williams, Jonathan
Publication Date: 2022
Journal: Disability & Rehabilitation 44(12), pp. 2683-2690
Abstract: PURPOSE: The aim of this study was to understand the views of falls service practitioners regarding: their role in supporting self-management of falls prevention; and a transition pathway from National Health Service (NHS) exercise-based falls interventions to community-run exercise programmes. METHOD: Semi-structured interviews were conducted with physiotherapists, nurses, and rehabilitation assistants (n = 8) who worked in an NHS falls service. Data were analysed using thematic analysis. RESULTS: Certain aspects of supporting patients in self-management were deemed to be within or beyond the scope of falls service practitioners. Challenges in supporting transition to community-run programmes included: practitioner awareness and buy in; patient buy in; and patient suitability/programme availability. CONCLUSION: Practitioners sought to be patient-centred as a means to engage patients in self-management of falls prevention exercises. Time-limited intervention periods and waiting list pressures were barriers to the promotion of long-term self-management approaches. A disconnect between falls service interventions and community-run programmes hindered willing practitioners from supporting patients in transitioning. Unless falls risk and prevention is seen by healthcare providers as a long-term condition which requires person-centred support from practitioners to develop self-management approaches, then falls services may only be able to offer short-term measures which are potentially not long lasting.IMPLICATIONS FOR REHABILITATIONFalls rehabilitation practitioners need to take a person-centred approach to engage patients in self-management of falls prevention exercises. Providing information and signposting to exercise opportunities such as community-run programmes following falls service interventions should be viewed as being within the scope of the role of falls service practitioners. Rehabilitation practitioners should consider viewing falls risk as a long-term condition, to promote longer-term behavioural change approaches to ongoing engagement of exercise for falls prevention.

Evaluating the impact of a training program to support transitioning from the hospital to the community for people after stroke: a community case study
Item Type: Journal Article
Authors: Lui, Michelle;McKellar, Katherine;Cooper, Shari;Eng, Janice J. and Bird, Marie-Louise
Publication Date: Jan 05 ,2022
Journal: BMC Health Services Research 22(1), pp. 30
Abstract: BACKGROUND: The transitions in care along the

stroke recovery path are challenging, particularly in finding mechanisms to continue one's recovery once at home. We aim to evaluate the impact of training physiotherapists and fitness instructors from one regional community together to deliver an evidence-based group exercise program starting in the hospital and transitioning to the community using an implementation approach. METHODS: The evidenced based exercise program Fitness and Mobility Exercise (FAME) for stroke was chosen as the intervention. Data from interviews with stakeholders (community centre and health authority hospital staff including a physiotherapy navigator) was transcribed and themes evaluated using the RE-AIM (Reach, Efficacy, Adoption, Implementation, Maintenance) framework. These data were supplemented by information collected as a quality assurance project within the health authority. RESULTS: Two programs were established; one in the community centre (run over 15 months by fitness instructors) and one in the regional hospital (run over 12 months by a rehabilitation assistant under the direction from a physiotherapist). Transitions in care were facilitated by implementing the same evidence-based group exercise class in both the hospital and community setting, so people living with stroke could seamlessly move from one to another. An existing physiotherapist navigator service also was valued as a support for the transitions between the two centres for people with stroke. The hospital group accessed group-based physiotherapy service on average 31 days earlier than they were able to in a one-to-one format. CONCLUSIONS: This case study described the implementation of the Fitness and Mobility Exercise (FAME) program in one community and the use of a physiotherapist navigator to assist transition between them. After a community training workshop, FAME programs were established within the health authority and the community centre. FAME program participants within the health authority benefited from reduced wait times to access hospital outpatient physiotherapy service. Improvements in function were measured in and reported by the people after stroke attending either the health authority or community centre FAME groups.

Home-based rehabilitation programme compared with traditional physiotherapy for patients at risk of poor outcome after knee arthroplasty: the CORKA randomised controlled trial.
Item Type: Journal Article
Authors: Barker, Karen L.;Room, Jonathan;Knight, Ruth;Dutton, Susan;Toye, Francine;Leal, Jose;Kenealy, Nicola;Maia Schlussel, Michael;Collins, Gary;Beard, David;Price, Andrew James;Underwood, Martin;Drummond, Avril;Lamb, Sarah and CORKA Trial group
Publication Date: 08 27 ,2021
Journal: BMJ Open 11(8), pp. e052598
Abstract: OBJECTIVES: To evaluate whether a home-based rehabilitation programme for people assessed as being at risk of a poor outcome after knee arthroplasty offers superior outcomes to traditional outpatient physiotherapy. DESIGN: A prospective, single-blind, two-arm randomised controlled superiority trial. SETTING: 14 National Health Service physiotherapy departments in the UK. PARTICIPANTS: 621 participants identified at high risk of a poor outcome after knee arthroplasty using a bespoke screening tool. INTERVENTIONS: A multicomponent home-based rehabilitation programme delivered by rehabilitation assistants with supervision from qualified therapists versus usual care outpatient physiotherapy. MAIN OUTCOME MEASURES: The primary outcome was the Late-Life Function and Disability Instrument (LLFDI) at 12 months. Secondary outcomes were the Oxford Knee Score (a disease-specific measure of function), Knee injury and Osteoarthritis Outcome Score Quality of Life subscale, Physical Activity Scale for the Elderly, 5 dimension, 5 level version of Euroqol (EQ-5D-5L) and physical function assessed using the Figure of 8 Walk test, 30 s Chair Stand Test and Single Leg Stance. RESULTS:

621 participants were randomised between March 2015 and January 2018. 309 were assigned to CORKA (Community Rehabilitation after Knee Arthroplasty) home-based rehabilitation, receiving a median five treatment sessions (IQR 4-7). 312 were assigned to usual care, receiving a median 4 sessions (IQR 2-6). The primary outcome, LLFDI function total score at 12 months, was collected for 279 participants (89%) in the home-based CORKA group and 287 participants (92%) in the usual care group. No clinically or statistically significant difference was found between the groups (intention-to-treat adjusted difference=0.49 points; 95% CI -0.89 to 1.88; p=0.48). There were no statistically significant differences between the groups on any of the patient-reported or physical secondary outcome measures at 6 or 12 months. There were 18 participants in the intervention group reporting a serious adverse event (5.8%), only one directly related to the intervention, all other adverse events recorded throughout the trial related to underlying chronic medical conditions. CONCLUSIONS: The CORKA intervention was not superior to usual care. The trial detected no significant differences, clinical or statistical, between the two groups on either primary or secondary outcomes. CORKA offers an evaluation of an intervention utilising a different service delivery model for this patient group. TRIAL REGISTRATION NUMBER: ISRCTN13517704. Copyright © Author(s) (or their employer(s)) 2021. Re-use permitted under CC BY. Published by BMJ.

Large-scale implementation of stroke early supported discharge: the WISE realist mixed-methods study.
Item Type: Journal Article
Authors: Fisher, Rebecca J.;Chouliara, Niki;Byrne, Adrian;Cameron, Trudi;Lewis, Sarah;Langhorne, Peter;Robinson, Thompson;Waring, Justin;Geue, Claudia;Paley, Lizz;Rudd, Anthony and Walker, Marion F.
Publication Date: 2021
Journal: Health Services and Delivery Research 9(22), pp. (November 2021)
Abstract: BACKGROUND: In England, the provision of early supported discharge is recommended as part of an evidence-based stroke care pathway. OBJECTIVES: To investigate the effectiveness of early supported discharge services when implemented at scale in practice and to understand how the context within which these services operate influences their implementation and effectiveness. DESIGN: A mixed-methods study using a realist evaluation approach and two interlinking work packages was undertaken. Three programme theories were tested to investigate the adoption of evidence-based core components, differences in urban and rural settings, and communication processes. SETTING AND INTERVENTIONS: Early supported discharge services across a large geographical area of England, covering the West and East Midlands, the East of England and the North of England. PARTICIPANTS: Work package 1: historical prospective patient data from the Sentinel Stroke National Audit Programme collected by early supported discharge and hospital teams. Work package 2: NHS staff (n=117) and patients (n=30) from six purposely selected early supported discharge services. DATA AND MAIN OUTCOME: Work package 1: a 17-item early supported discharge consensus score measured the adherence to evidence-based core components defined in an international consensus document. The effectiveness of early supported discharge was measured with process and patient outcomes and costs. Work package 2: semistructured interviews and focus groups with NHS staff and patients were undertaken to investigate the contextual determinants of early supported discharge effectiveness. RESULTS: A variety of early supported discharge service models had been adopted, as reflected by the variability in the early supported discharge consensus score. A one-unit increase in early supported discharge consensus score was significantly associated with a more responsive early supported discharge

service and increased treatment intensity. There was no association with stroke survivor outcome. Patients who received early supported discharge in their stroke care pathway spent, on average, one day longer in hospital than those who did not receive early supported discharge. The most rural services had the highest service costs per patient. NHS staff identified core evidence-based components (e.g. eligibility criteria, co-ordinated multidisciplinary team and regular weekly multidisciplinary team meetings) as central to the effectiveness of early supported discharge. Mechanisms thought to streamline discharge and help teams to meet their responsiveness targets included having access to a social worker and the quality of communications and transitions across services. The role of rehabilitation assistants and an interdisciplinary approach were facilitators of delivering an intensive service. The rurality of early supported discharge services, especially when coupled with capacity issues and increased travel times to visit patients, could influence the intensity of rehabilitation provision and teams' flexibility to adjust to patients' needs. This required organising multidisciplinary teams and meetings around the local geography. Findings also highlighted the importance of good leadership and communication. Early supported discharge staff highlighted the need for collaborative and trusting relationships with patients and carers and stroke unit staff, as well as across the wider stroke care pathway. LIMITATIONS: Work package 1: possible influence of unobserved variables and we were unable to determine the effect of early supported discharge on patient outcomes. Work package 2: the pragmatic approach led to 'theoretical nuggets' rather than an overarching higher-level theory. CONCULSIONS: The realist evaluation methodology allowed us to address the complexity of early supported discharge delivery in real-world settings. The findings highlighted the importance of context and contextual features and mechanisms that need to be either addressed or capitalised on to improve effectiveness. TRIAL REGISTRATION: Current Controlled Trials ISRCTN15568163. FUNDING: This project was funded by the National Institute for Health Research (NIHR) Health Services and Delivery Research programme. [Abstract]

The role of the nurse in the community stroke rehabilitation team: a personal perspective Abstract only*
Item Type: Journal Article
Authors: Townshend, Brenda
Publication Date: 2020
Journal: British Journal of Neuroscience Nursing 16, pp. S6-S8
Abstract: Excellent patient care often requires the collaboration of a range of health professionals, and stroke patient rehabilitation is no exception. Brenda Townshend offers insights from her personal journey as a nurse in a London-based community stroke rehabilitation team.

Recruitment challenges in stroke rehabilitation randomized controlled trials: a qualitative exploration of trialists' perspectives using Framework analysis. Abstract only*
Item Type: Journal Article
Authors: McGill, Kris;McGarry, Jodie;Sackley, Catherine;Godwin, Jon;Nicoll, Avril and Brady, Marian C.
Publication Date: Aug ,2020
Journal: Clinical Rehabilitation 34(8), pp. 1122-1133
Abstract: OBJECTIVE: To explore the underlying reasons for recruitment difficulties to stroke rehabilitation randomized controlled trials from the perspective of trialists. DESIGN: A qualitative study using semi-structured interviews and Framework analysis. PARTICIPANTS: Twenty multidisciplinary stroke rehabilitation trialists across 13 countries with a range of clinical and research experience. METHODS: Twenty semi-structured telephone interviews were carried out. Purpose ful sampling ensured a range of opinions were gathered from across the international stroke rehabilitation research community. Using Framework analysis, the analytical framework

was formed by three researchers and tested before being applied to the total dataset. RESULTS: Three themes described the trialists' perception of the underlying reasons for recruitment difficulties: (i) decision making, (ii) importance of recruiters and (iii) a broken system. Trialists described frequently disregarding evidence in favour of prior research experiences when planning randomized controlled trial recruitment. All felt that the relationship between the research and clinical teams was vital to ensure recruiters prioritized and found value in recruitment to the trial. Experienced trialists were frustrated by the lack of reporting of the reality of running trials, research governance demands and the feeling that they had to deliberately underestimate recruitment timeframes to secure funding. CONCLUSION: Stroke rehabilitation trialists described recruitment difficulties which may be related to their experiential based recruitment decision making, a lack of understanding of how best to incentivize and maintain relationships with recruiters and unrealistic bureaucratic expectations both in terms of gaining funding and research governance.

Frailty: An in-depth qualitative study exploring the views of community care staff.
Item Type: Journal Article
Authors: Coker, J. F.;Martin, M. E.;Simpson, R. M. and Lafortune, L.
Publication Date: 2019
Journal: BMC Geriatrics 19(1), pp. no pagination
Abstract: Background: Frailty is seen across various health and social care settings. However, little is known about how healthcare professionals, particularly those who provide care for older adults living in the community view frailty. There is also a dearth of information about the extent to which a shared understanding of frailty exists across the various disciplines of care. Such an understanding is crucial across care professionals as it ensures consistent assessment of frailty and facilitates interdisciplinary working/collaboration which is a key component in the management of frailty. This study aimed to explore: (i) how community care staff from various specialties viewed frailty; (ii) whether they had a shared understanding; and (iii) how they assessed frailty in everyday practice. Method(s): Semi-structured interviews were conducted with a purposive sample of 22 community care staff from seven specialties, namely: healthcare assistants, therapy assistants, psychiatric nurses, general nurses, occupational therapists, physiotherapists and social workers, recruited from four neighbourhood teams across Cambridgeshire, England. Interviews were analysed thematically. Result(s): There was a shared narrative among participants that frailty is an umbrella term that encompasses interacting physical, mental health and psychological, social, environmental, and economic factors. However, various specialities emphasised the role of specific facets of the frailty umbrella. The assessment and management of frailty was said to require a holistic approach facilitated by interdisciplinary working. Participants voiced a need for interdisciplinary training on frailty, and frailty tools that facilitate peer-learning, a shared understanding of frailty, and consistent assessment of frailty within and across specialities. Conclusion(s): These findings underscore the need to: (i) move beyond biomedical descriptions of frailty; (ii) further explore the interacting nature of the various components of the frailty umbrella, particularly the role of modifiable factors such as psychological and socioeconomic resilience; (iii) care for frail older adults using holistic, interdisciplinary approaches; and (iv) promote interdisciplinary training around frailty and frailty tools to facilitate a shared understanding and consistent assessment of frailty within and across specialities. Copyright © 2019 The Author(s).

Developing a holistic, multidisciplinary community service for frail older people. Abstract only*
Item Type: Journal Article
Authors: Featherstone, Amanda
Publication Date: 11 29 ,2018
Journal: Nursing Older People 30(7), pp. 34-40
Abstract: This article explores the development of an ambulatory community service that demonstrates multidisciplinary working to meet the diverse needs of frail older people and their carers. The service comprises advanced nurse practitioners, a pharmacist, a community navigator, consultants, occupational therapists, physiotherapists, a nurse, rehabilitation assistants, a healthcare assistant and an administrator. This multidisciplinary team (MDT) serves adults with complex medical and rehabilitation needs who are being discharged from hospital, staying in bedded rehabilitation units or living at home by offering assessments, investigations and rehabilitation, where appropriate closer to home. The aims of the service are to: keep people well, prevent unplanned hospital admissions, promote health and well-being, reduce the risk of falls, enable independent living and provide rehabilitation. Personalised care plans are developed with patients and their carers. Advanced nursing practice is demonstrated in assessment, investigation, diagnosis, management, referral and non-medical prescribing. Development of this MDT is required to support and promote integrated, evidence-based work. Such development leads to integrated care across communities, and bridges gaps between patients and carers, GPs, home, residential and hospital-based services, and the voluntary, statutory and non-statutory sectors.

A modelling tool for capacity planning in acute and community stroke services
Item Type: Journal Article
Authors: Monks, Thomas;Worthington, David;Allen, Michael;Pitt, Martin;Stein, Ken and James, Martin A.
Publication Date: 2016
Journal: BMC Health Services Research 16, pp. 530
Abstract: Background: Mathematical capacity planning methods that can take account of variations in patient complexity, admission rates and delayed discharges have long been available, but their implementation in complex pathways such as stroke care remains limited. Instead simple average based estimates are commonplace. These methods often substantially underestimate capacity requirements. We analyse the capacity requirements for acute and community stroke services in a pathway with over 630 admissions per year. We sought to identify current capacity bottlenecks affecting patient flow, future capacity requirements in the presence of increased admissions, the impact of co-location and pooling of the acute and rehabilitation units and the impact of patient subgroups on capacity requirements. We contrast these results to the often used method of planning by average occupancy, often with arbitrary uplifts to cater for variability. Methods: We developed a discrete-event simulation model using aggregate parameter values derived from routine administrative data on over 2000 anonymised admission and discharge timestamps. The model mimicked the flow of stroke, high risk TIA and complex neurological patients from admission to an acute ward through to community rehab and early supported discharge, and predicted the probability of admission delays. Results: An increase from 10 to 14 acute beds reduces the number of patients experiencing a delay to the acute stroke unit from 1 in every 7 to 1 in 50. Co-location of the acute and rehabilitation units and pooling eight beds out of a total bed stock of 26 reduce the number of delayed acute admissions to 1 in every 29 and the number of delayed

rehabilitation admissions to 1 in every 20. Planning by average occupancy would resulted in delays for one in every five patients in the acute stroke unit. Conclusions: Planning by average occupancy fails to provide appropriate reserve capacity to manage the variations seen in stroke pathways to desired service levels. An appropriate uplift from the average cannot be based simply on occupancy figures. Our method draws on long available, intuitive, but underused mathematical techniques for capacity planning. Implementation via simulation at our study hospital provided valuable decision support for planners to assess future bed numbers and organisation of the acute and rehabilitation services.

Centralising acute stroke care and moving care to the community in a Danish health region: Challenges in implementing a stroke care reform.
Item Type: Journal Article
Authors: Douw, Karla;Nielsen, Camilla Palmhoj and Pedersen, Camilla Riis
Publication Date: Aug ,2015
Journal: Health Policy 119(8), pp. 1005-1010
Abstract: In May 2012, one of Denmark's five health care regions mandated a reform of stroke care. The purpose of the reform was to save costs, while at the same time improving quality of care. It included (1) centralisation of acute stroke treatment at specialised hospitals, (2) a reduced length of hospital stay, and (3) a shift from inpatient rehabilitation programmes to community-based rehabilitation programmes. Patients would benefit from a more integrated care pathway between hospital and municipality, being supported by early discharge teams at hospitals. A formal policy tool, consisting of a health care agreement between the region and municipalities, was used to implement the changes. The implementation was carried out in a top-down manner by a committee, in which the hospital sector--organised by regions--was better represented than the primary care sector-organised by municipalities. The idea of centralisation of acute care was supported by all stakeholders, but municipalities opposed the hospital-based early discharge teams as they perceived this to be interfering with their core tasks. Municipalities would have liked more influence on the design of the reform. Preliminary data suggest good quality of acute care. Cost savings have been achieved in the region by means of closure of beds and a reduction of hospital length of stay. The realisation of the objective of achieving integrated rehabilitation care between hospitals and municipalities has been less successful. It is likely that greater involvement of municipalities in the design phase and better representation of health care professionals in all phases would have led to more successful implementation of the reform. Copyright © 2015 The Authors. Published by Elsevier Ireland Ltd.. All rights reserved.

Community stroke rehabilitation teams: providing home-based stroke rehabilitation in Ontario, Canada.
Item Type: Journal Article
Authors: Allen, L.;Richardson, M.;McIntyre, A.;Janzen, S.;Meyer, M.;Ure, D.;Willems, D. and Teasell, R.
Publication Date: Nov ,2014
Journal: Canadian Journal of Neurological Sciences 41(6), pp. 697-703
Abstract: BACKGROUND: Community stroke rehabilitation teams (CSRTs) provide a community-based, interdisciplinary approach to stroke rehabilitation. Our objective was to assess the effectiveness of these teams with respect to client outcomes. METHODS: Functional, psychosocial, and caregiver outcome data. were available at intake, discharge from the program, and six-month follow-up. Repeated measures analysis of covariance was performed to assess patient changes between time points for each outcome measure. RESULTS: A total of 794 clients met the inclusion criteria for analysis (54.4% male, mean age 68.5+/-13.0 years). Significant changes were found between intake and

discharge on the Hospital Anxiety and Depression Scale total score (p=0.017), Hospital Anxiety and Depression Scale Anxiety subscale (p<0.001), Functional Independence Measure (p<0.001), Reintegration to Normal Living Index (p=0.01), Bakas Caregiver Outcomes Scale (p<0.001), and Caregiver Assistance and Confidence Scale assistance subscale (p=0.005). Significant gains were observed on the strength, communication, activities of daily living, social participation, memory, and physical domains of the Stroke Impact Scale (all p<0.001). These improvements were maintained at the 6-month follow-up. No significant improvements were observed upon discharge on the memory and thinking domain of the Stroke Impact Scale; however, there was a significant improvement between admission and follow-up (p=0.002). All significant improvements were maintained at the 6-month follow-up. CONCLUSIONS: Results indicate that the community stroke rehabilitation teams were effective at improving the functional and psychosocial recovery of patients after stroke. Importantly, these gains were maintained at 6 months postdischarge from the program. A home-based, stroke-specific multidisciplinary rehabilitation program should be considered when accessibility to outpatient services is limited.

Implementing evidence-based stroke Early Supported Discharge services: A qualitative study of challenges, facilitators and impact.
Item Type: Journal Article
Authors: Chouliara, N.;Fisher, R. J.;Kerr, M. and Walker, M. F.
Publication Date: 2014
Journal: Clinical Rehabilitation 28(4), pp. 370-377
Abstract: Objectives: To explore the perspectives of healthcare professionals and commissioners working with a stroke Early Supported Discharge service in relation to: (1) the factors that facilitate or impede the implementation of the service, and (2) the impact of the service. Design(s): Cross-sectional qualitative study using semi-structured interviews. Data were analysed by two researchers using a thematic analysis approach. Setting(s): Two Early Supported Discharge services in Nottinghamshire. Participant(s): Purposive sampling identified 35 key informants including practitioners, managers and commissioners. Result(s): The identified facilitators to the implementation of evidence-based services were: (1) the adaptability of the intervention to the healthcare context, (2) the role of rehabilitation assistants and (3) cross-service working arrangements. Perceived challenges included: (1) lack of clarity regarding the referral decision making process, (2) delays in securing social care input and (3) lack of appropriate followon services in the region. Most respondents perceived the impact of the services to be: (1) reducing inhospital stay, (2) aiding the seamless transfer of care from hospital to the community and (3) providing intensive stroke specific therapy. Commissioners called for greater evidence of service impact and clarity regarding where it fits into the stroke pathway. Conclusion(s): Early Supported Discharge services were perceived as successful in providing homebased, stroke specific rehabilitation. Teams would benefit from capitalising on identified facilitators and developing strategies to address the challenges. The remit and impact of the services should be clear and demonstrable, with teams strengthening links with other health and social care providers. © The Author(s) 2013.

The role of the community stroke rehabilitation nurse. Abstract only*
Item Type: Journal Article
Authors: McGinnes, Alison;Easton, Sarah;Williams, Jane and Neville, Janet
Publication Date: 2013
Journal: British Journal of Nursing 19(16), pp. 1033-1038
Abstract: There is strong evidence for early supported discharge (ESD) following stroke, but there is no evidence on how these services should be organized or the best models of care. ESD

teams rarely include a community stroke rehabilitation nurse. A service development project was undertaken in Portsmouth Hospitals NHS Trust's community stroke rehabilitation team to identify and explore the unique contributions of community stroke rehabilitation nurses in an established ESD team. When the team was set up, the nurses had inpatient stroke rehabilitation skills, but no community experience. This novel approach, which involved taking specialist hospital nurses into the community, meant there was a steep learning curve and, unfortunately, there were no role models to support their development. During these early days, it became apparent that intensive stroke rehabilitation within an interdisciplinary ESD team required effective and timely nursing intervention, the development of skills to support interdisciplinary working and a greater understanding of the roles of all team members. Locally and nationally, questions were being asked pertaining to the nurses' role, which precipitated this project. Through a series of journal club sessions, the interdisciplinary team reviewed the evidence base of the nurse role in stroke rehabilitation. The team were able to evaluate findings against current practice. The project confirmed that the community stroke rehabilitation nurse provides a unique and fundamental role to the team that strengthens the model of interdisciplinary teamworking.

A supportive home visit program for older adults implemented by non-professionals: Feasibility and effects on physical performance and quality of life at one year - A pilot study.
Abstract only*
Item Type: Journal Article
Authors: Niemela, K.;Leinonen, R. and Laukkanen, P.
Publication Date: 2012
Journal: Archives of Gerontology and Geriatrics 54(3), pp. e376-e382
Abstract: Knowledge of supportive home rehabilitative procedures is needed to improve the independent home training and psychosocial wellbeing of older people. The primary focus of this study was to assess the feasibility of a home visit program involving the use of non-professional home rehabilitation assistants (HRAs) support among elderly. The secondary objective was to investigate the effects to physical performance and health-related quality of life (HRQL) of older people. A controlled intervention study was implemented at two war veterans' rehabilitation centers in Finland. The study included 22 long-term unemployed people aged 26-58 years, who were educated in HRA tasks and 417 community-dwelling persons aged 65-99 years, who participated in 10-28 days of inpatient rehabilitation. The intervention group (IG) received 10-14-month physiotherapist-supervised HRA home visit program. The control group (CG) received no home visit intervention. Additional information was collected to assess the feasibility of the intervention. Structured interviews were carried out. Physical performance was evaluated through several validated tests, pain with the Visual Analog Scale (VAS), and HRQL with the Leipad questionnaire. The HRAs adopted their supporting role through the social activation of the rehabilitees and continued to study to become practical nurses. At 10-14 months, HRQL among women (p= 0.029) and chair rising among men (p= 0.028) improved in the IG but declined in the CG. The supportive home visit program was feasible and improved the HRQL in women and chair rising in men. This model could motivate long-term unemployed people to educate themselves. © 2011 Elsevier Ireland Ltd.

Evaluating new roles for the support workforce in community rehabilitation settings in Queensland. Abstract only*
Item Type: Journal Article
Authors: Wood, Angela J.;Schuurs, Sarita B. and Amsters, Delena I.
Publication Date: Feb ,2011
Journal: Australian Health Review 35(1), pp. 86-91

Abstract: INTRODUCTION: Alternative workforce models need to be explored to adequately meet the future health care needs of the Australian population. A new role for the support workforce, to optimise their contribution in community rehabilitation in Queensland--the advanced community rehabilitation assistant (ACRA)--was developed on the basis of service activity mapping and gap analysis. OBJECTIVES: Evaluation of a trial of the new ACRA role at six pilot sites in Queensland. PARTICIPANTS: ACRAs, health professionals and rehabilitation clients. METHODS: Transcripts of semistructured telephone interviews conducted with ACRAs, health professionals and rehabilitation clients were thematically analysed. The nature of the role as well as perceived strengths and weaknesses were explored. RESULTS: The presence of an ACRA was generally seen to diversify and expand local service capacity. The major challenge was the initial intensity of instruction that was required from supervising health professionals. CONCLUSIONS: ACRAs have potential to be valuable resources in the provision of community rehabilitation services. The challenge of meeting each new ACRA's preliminary training needs requires further consideration. A critical mass of people trained to this role may be required to ensure sustainability. Further trial and evaluation is needed to investigate the role more thoroughly over time and in different settings.

Competency Frameworks

Allied Health Professions' Support Worker Competency, Education, and Career Development Framework
Source: Health Education England
This framework enables employers, networks, integrated care systems (ICSs) and services effectively plan, develop, and deploy their AHP support workforce. It provides guidance on training, education and competencies for AHP support workers and demonstrates a clear pathway for recruitment and progression, with common and transferrable skills across eight domains.

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