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Addressing the Organisation of Home-Based Rehabilitation

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Introduction

Increased numbers of older people, many more people living with chronic conditions together with and falling lengths of hospital stay have necessitated a need in many countries for more home-based rehabilitation. There is as yet no full or widely used definition of rehabilitation, but a model of the process has been proposed [1]: rehabilitation is an educational, problem-solving process that focuses on activity limitation and aims to optimise patient social participation and well-being, thus reducing stress on the carer/family. Emphasis is placed on the users' own goals in the rehabilitation process and on them being given help to formulate a different understanding of their situation within a new framework [1,2]. User participation is vital. Home-based rehabilitation makes it possible to base the rehabilitation process on daily activities in home surroundings, and to make use of local services in the rehabilitation process which makes it easier for the patient to resume earlier activities, possibly adapted to a new situation. For older patients, home-based rehabilitation appears to be as effective as rehabilitation in a care home, in hospital or in a day hospital [3,4]. Home-based rehabilitation seems better than usual home care, and intensive home-based rehabilitation is better than non-intensive [5]. Coordinated services are necessary and working in teams is to be preferred [6].

Home-based Rehabilitation in Practice, the Case of Oslo, Norway

In a research project we aimed to use general policy guidelines and staff experience of rehabilitation work in two boroughs in Oslo to develop a model for the organisation of and cooperation on home-based rehabilitation [7]. The research project was conducted in collaboration between two researchers, employees in two Oslo boroughs and the Norwegian Association for Stroke Survivors, who contributed user experience at three meetings [ibid].

The Norwegian healthcare system is divided into two separate governmental levels: the specialist and the primary healthcare systems. Norwegian hospitals are organised within the specialist healthcare system, while the municipalities hold the responsibility for primary health care, institutional long term services, home based care, and the provision of social care services. In the two boroughs studied home nursing and practical assistance are organised according to a purchaser-provider split model with a clear distinction between those who assess the need for a service and determine the scope of the services and those who provide them in practice [8,9]. With our departure point in general policy guidelines and staff experience of rehabilitation work, we chose to conduct a practice research study with an action research design that combines knowledge generation and improvement of practice [10]. Qualitative data were gathered in seven group meetings and 24 individual interviews in the boroughs. The interview transcripts and records from meetings were analysed using a systematic text condensation method [11]. The first step of the analysis was to read all the material to obtain an overall impression. We then re-read the material and noted relevant topics that were discussed at meetings and interviews, identified meaning-bearing units associated with the topics, coded them and assembled them in code groups under their respective headings. In the third step we condensed the contents of each code group. The last step was to condense the texts into accounts-an analytical text-that constituted our results [7].

Norwegian municipalities are required to provide a rehabilitation service to everyone in the municipality who is in need of it. Despite the fact that it is well documented that home-based rehabilitation is effective, the results of this study show that rehabilitation receives little attention in the home-based services of the boroughs, and that patients are seldom rehabilitated at home. The results also show that there is disagreement among staff in the two boroughs as to what rehabilitation is and should be, and even doubts about delimiting rehabilitation as a separate activity. Various professional groups communicated different focuses and ideologies regarding rehabilitation. Staff at managerial level seemed to be reluctant to define and delimit the activity, perhaps because rehabilitation is linked to increased resources. Lack of time was constantly cited as a major constraint in the rehabilitation work. Many described limited resources in the home-based services and strict prioritising; they had to keep to the budget. Many informants were critical to the purchaser-provider organisation of home-based nursing and practical assistance, and hold the view that purchaser's splitting up the work hampers rehabilitation. Further the purchaser lacked rehabilitation competence, and physiotherapists and occupational therapists were not represented in the purchasing office of the two boroughs. This may be one reason that rehabilitation receives little attention. Interdisciplinary collaboration was stated as a prerequisite for a good rehabilitation service, and insufficient team work was described in both boroughs. Many employees asked for someone to have the paramount responsibility for organizing the collaboration. The results show a clear lack of anchorage of rehabilitation work in the two boroughs' organisations, and one rehabilitation case we followed in the research project, clearly reflected the lack of a coordination system.

There is, in general, a lack of competence and capacity in home-based rehabilitation in Norwegian municipalities [12]. Despite comprehensive guidelines, the implementation of rehabilitation services has been disappointing also in other countries [13,14].

Rehabilitation received considerable attention in both boroughs during our action research project and the field underwent distinct development. Representatives of various services and offices and different levels in the organisation were involved. As a result of constant discussions on what rehabilitation is and how it is to be

organised, rehabilitation was more precisely defined and this enabled the staff to obtain a clearer and more consensual understanding of the field. Further the employees discussed and agreed on criteria for those who are to be rehabilitated: persons with loss of physical function but with potential/motivation and a functional level sufficient to enable improvement of function, and with a need for at least three services. Above all they developed a model for the organisation of and cooperation on rehabilitation with the rehabilitation anchored in the organisation via a coordinating unit and the interdisciplinary work organised in a rehabilitation team.

Coordinating Unit

The need for someone to have the paramount responsibility for rehabilitation in the borough was a recurring theme at the meetings and interviews in both boroughs. A prominent and well defined coordinating unit (CU) was developed in the course of the project period. The unit was located in the purchasing office and was given a clear systemic responsibility for routines and training in the areas of cooperation on users requiring coordinated services, individual rehabilitation plans patient care teams and coordinator. In addition, the CU was required to maintain an overview of the rehabilitation service in the borough. On the individual level, the CU's responsibility involves receiving all communications concerning the need for home-based rehabilitation and initiating interdisciplinary cooperation by contacting the rehabilitation team, which has the responsibility for the further rehabilitation work and cooperation on the practical level (Figure 1).

Rehabilitation team

Recognizing that inter-professional collaboration is personally, professionally and organisationally demanding, the employees came to the conclusion that they wanted to organise their collaboration in a rehabilitation team. A physiotherapist, an occupational therapist, a representative for home nursing and one for practical assistance were members, plus a representative from the coordinating unit in the purchasing office. The CU's cooperation with the team is crucial: the CU is to contact the rehabilitation team when receiving a request or an application about the need for rehabilitating. The team members normally do their usual work, but must be able to step in as needed to determine whether a patient should be rehabilitated or not. If rehabilitation is approved, the team is to assess the need for assistance, and because the purchasing office is represented in the team, the team has the authority to allocate services. The team must work intensively for a period-preparing a rehabilitation plan, establishing a patient care team, appointing a coordinator, and starting a rehabilitation programme. The team then withdraws, and the ordinary home-based services continue the rehabilitation process. The patient care team with the providers performing the rehabilitating work continues throughout the rehabilitation process. In this way the patient gets highly competent assistance in the first, important phase of the rehabilitation process.

The Distinctive Character of Rehabilitation Work

Rehabilitation implies complicated and interwoven work tasks, while modern management ideologies-with management by objectives and results-require rehabilitation work to be broken down into smaller, measurable units. Larger Norwegian municipalities, including all the boroughs in Oslo, have chosen to organise their home-based services according to a purchaser-performer model. The point is that decisions concerning services are taken according to standardised time estimates per part-task by someone who is not close to the patient. Making a rehabilitation diagnosis, however, requires clinical competency and must be done by professionals who monitor the patient over time [15].

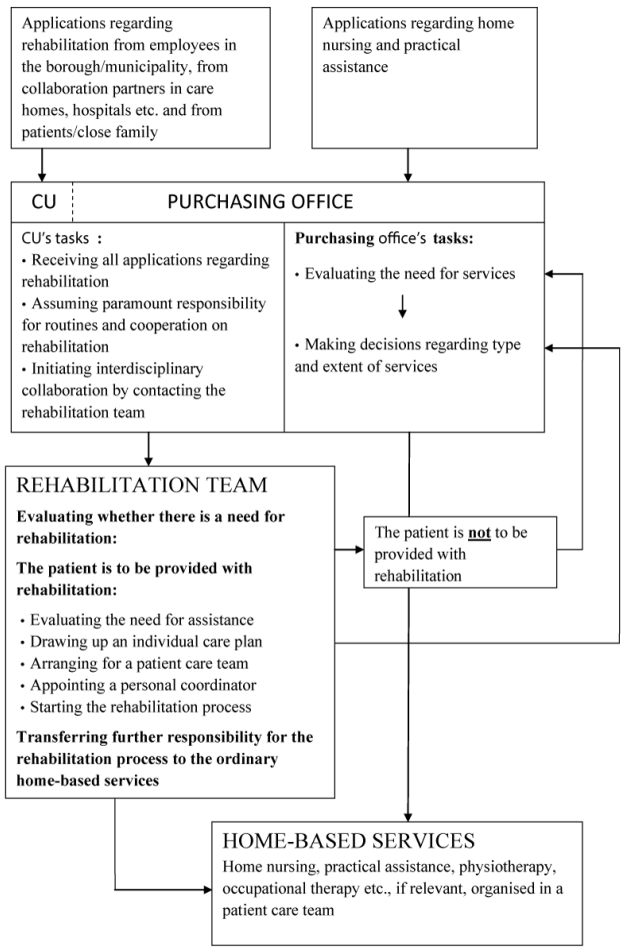

Figure 1: A schematic model for rehabilitation in a borough/municipality.

Wade points out that individuality are the opposite of standardisation. The patient's rehabilitation needs may vary considerably over time, and a tightly managed service can make it difficult to offer good rehabilitation services adjusted to rapidly changing needs. The rehabilitation team may to a certain extent compensate for the purchaser's splitting up the services and for lack of rehabilitation competence in the purchaser office. One additional advantage of this form of organisation is that when the team transfers the responsibility for further rehabilitation to the home-based services, these services are given plentiful opportunities for learning practical rehabilitation in daily nursing.

Busyness, few meeting places and time pressure on service delivery provide challenging conditions for collaboration. Knowledge of each other's roles and inter-professional trust are prerequisites, and this demands time and meeting places. It is well documented in literature

that the team is an appropriate organisation of cooperation [16]. A well organised rehabilitation team may be appropriate. When the rehabilitation team's participants know each other from the start, the cooperation will probably be facilitated. McColl points out that this arrangement gives more practical, academic and emotional support to team members; it broadens the potential range of interventions and expertise available to the patient [16]. Rehabilitation places emphasis on the users' own goals [1,2]. Kendall stresses commitment to the user as an important rehabilitation competency, i.e. understanding the user's preferences, making user participation possible, and involving the user in the process [17]. This is a matter of personal qualities and skills such as the ability to listen, patience, and the ability to engage in dialogue and discussion. These skills can to a certain extent be learned, and this is conditional on an organisation and management that support learning and a culture that values good practice. This requires that rehabilitation is integrated in the organisation and anchored in the management and that the responsibility for training is clearly defined.

Conclusions

It is likely that the model for organisation of and cooperation on rehabilitation described here can reduce important challenges in rehabilitation. A distinct model approved by employees on different organisational levels can probably be time-and resource saving. The coordinating unit's paramount responsibility for rehabilitation ensures that rehabilitation as an acknowledged activity has its anchorage in the organisation. The rehabilitation team provide competence in deciding the patient's need for rehabilitation and in starting the rehabilitation process, and constitute a suitable structure for the interdisciplinary collaboration. When implementing a model like this, all levels of the organisation ought to be involved in the development work in order to legitimise the model in the organisation. Moreover, it is important not to make the process too bureaucratic. Working in groups with representatives from different occupational groups, different service locations and different levels was found suitable. It is probably judicious to spend time on reaching agreement on what is to be done in rehabilitation, who is to have the responsibility and who is to perform the work-a description of the work process that must be followed, even if those involved may not agree on all the details.

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