Needs and Opportunities in Rehabilitation

Rehabilitation of the elderly: 1—Settings and services

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A man who insisted on having his hat taken off by the staff of his residential home after hours at the day hospital doing things for himself illustrates one of the challenges of geriatric rehabilitation: someone may be encouraged to do more than he or she normally does, but this may be no use unless rehabilitation takes account of the person's actual life, and relatives and care givers are involved as well.

The aims and elements of rehabilitation

Isaacs describes the possible targets—much the same as in rehabilitation of younger people—as restoration of lost function and the person's former role; maximal use of remaining function and attainment of an altered role; or adaptation to reduced function and a reduced role.¹ With realistic individually tailored targets rehabilitation failures, he points out, should be rare—and they reflect not the “moral turpitude” of the patient but professional errors. The assessment depends on knowing not only what the patient's present state is but “who he was, who he is and how he got there.” Thus the doctor (and other professionals) should if possible see patients and relatives “in their own environment and [listen] to talk about things that matter to them.”¹ In this way rehabilitation can be based both on realism and on sensitivity to the individual's personality and wishes.² Even if, as often happens, only small improvements are possible and independence is not to be hoped for, a rehabilitation approach may increase morale and self esteem and lead people to make the most of what is left to them, or at least help to make their lives a little less barren (I return to this theme in the next article). Rehabilitation may also mean helping them to keep an attractive and resilient personality, to quote Arie, despite disability.³

With the elderly, it was said to me, everything is rehabilitation, even in acute illness: indeed, geriatrics has been ahead of general medicine in putting rehabilitation at the centre—patients are soon up and dressed, for example, and encouraged to get going again. Ideas and good practices abound and in many centres this is a developing and exciting area to work in. The multiplicity of disorders and difficulties in old age makes it especially important to pinpoint the separate strands of disability, searching for causes that can be remedied or modified.⁴ The expectations of patient and family, and even doctors, are often low; and social and economic adversity may well, of course, compound health problems at this time of life. So the team approach—with a truly interdisciplinary, cohesive team working together—is here more than ever crucial to the planning process that must underpin rehabilitation. Workers emphasise the need for regular case conferences attended by everyone concerned, for discussing progress and barriers to progress and deciding on new strategies as needed; at case conferences I have attended I have been struck by the detailed

picture that emerged for each person discussed. Nevertheless, professional attitudes may still reflect nihilism or a laissez faire philosophy rather than the dynamic approach to rehabilitation. Resources are not the only factor: centres of excellence, someone said, excel at doing sensible things with mainly simple resources.

The main elements of rehabilitation are preventing complications such as contractures and pressure sores by early activity and physiotherapy; use of specialised techniques, including reality orientation (to be discussed in the next article), speech stimulation (to be discussed in the context of stroke), and the various techniques and agents used in physiotherapy⁵; training in the activities of daily living and provision of aids and appliances (19 January, p 220); provision and coordination of services; and advising, educating, and supporting carers. Many procedures and practices are assumed to be good but hard evidence is lacking. There is a great need for more evaluation studies on effects or on the best intensity or manner of delivery of treatments, but measurement of outcome may be difficult and large numbers of patients needed. In this article I look at the different contexts for rehabilitation and in the next at some activities and approaches.

Different settings of rehabilitation

HOSPITAL

Rehabilitation should start early—in some cases even before admission to hospital. This idea has been most developed in geriatric orthopaedics. At the Royal East Sussex Hospital, Hastings, any elderly person needing a hip or knee replacement attends a “total care” clinic for immediate assessment and advice, including instruction in exercises.^{6,7} When the operation is in sight patients attend a preadmission assessment clinic, where besides doing routine investigations staff gain a picture of the patient's circumstances and likely needs after operation. A physiotherapist teaches the exercises to be done after the operation and an occupational therapist may teach the use of aids. With fractures the approach is similar, with active rehabilitation and minimum bed rest after surgery. This “high turnover” system was commended by the DHSS⁸ and is being tried elsewhere⁹; the general principles could be applied to other kinds of elective operation.

Physiotherapists and occupational therapists are obvious essentials for many elderly people in hospital; but a national study of resources in geriatric medicine has shown that numbers of both are quite inadequate and not likely to become adequate.¹⁰ A special grade of rehabilitation nurse has been recommended for staffing wards needing a strong element of rehabilitation.¹⁰ Gradual withdrawal of nursing support is part of good rehabilitation and nurses, it is emphasised, should always encourage self help and activities taught by therapists.

DISCHARGE FROM HOSPITAL

Early discharge from hospital means especially careful preparation for going home: assessment by occupational therapists in the

activities of daily living, a careful study of home circumstances, and retraining and provision of aids and appliances as well as home services as needed. Short trial visits home before discharge may be helpful, and relatives need to become involved at this stage if not before. At Northwick Park Hospital, Harrow, a volunteer may visit a patient who lives alone on the day of discharge and during the first fortnight, to chat, do some chores, establish liaisons, and report to the social worker. Early discharge also makes it particularly important for a social worker or health visitor to check on how a patient is faring, and for immediate readmission to be guaranteed should things go wrong.

In the occupational therapy kitchen at the geriatric day hospital of St Helen's Hospital, Hastings.

Some consultants I have met have been enthusiastic about predischarge flatlets within geriatric and other units. Relatives may be admitted as well, and patients can be realistically assessed for coping at home: will they in practice do as much as they are capable of, and can the family manage?

At one hospital I saw a double bedded room where a spouse could be admitted with the patient from the start. The role—and the admission—of the spouse in rehabilitation of the elderly was emphasised by Cosin,¹¹ who pioneered rehabilitation in an integrated system of short term, long term, and day care in Oxford. Information and advice on sexual problems are given by SPOD (Association to Aid the Sexual and Personal Relationships of the Disabled), and this is one of many subjects covered by two invaluable handbooks.^{12 13}

Before discharge attention to aids and the adaptations needed at home (see 19 January, p 220) is crucial. These should be prompt (which they often are not), simple, and if necessary individually tailored. Too often no one person is totally responsible for this side of things, and in many cases no one looks later at the use, misuse, or neglect of aids and the many things that can go wrong. Case conferences provide useful checks. In a North Tyneside survey

around a third of handicapped people over 65 responding to the questions wanted bath, shower, or toilet aids and modifications, and 60% wanted advice on aids and equipment.¹⁴ Those who are on their own may be able to return home if they have an alarm device (aids centres and publications deal with these—details on pp 134-5, 12 January). But the more technological aids are not always acceptable to older people with established disabilities; and we must develop, says Wolff, a “cultural expectation” of the need for these different tools for living long before old age.¹⁵ A report from the EEC recommends that case histories should be compiled to illustrate “the sequence of steps required from the initial recognition of an individual's need to the successful adoption of a technological aid.”¹⁶ The “Senior Shoppers’ Fair” was an interesting venture by the Institute of Bioengineering of Brunel University and Age Concern in Brighton last August. *Coping with Disability*¹⁷ and *Help Yourself: A Handbook for Hemiplegics*¹³ are two most useful handbooks in this connection for patients and families (the former also for professionals).

THE COMMUNITY

Day hospitals, providing a kind of half way house, are crucial to the policy of early discharge, though they do have some disadvantages (see below). “Partial care” was described to me as the best idea in the past 40 years. Day hospitals, unlike day centres, provide for individual therapy and group rehabilitation activities as well as medical treatment, access to a specialist multidisciplinary team and specialist equipment, and help with self care if necessary; those who are pessimistic about themselves can be encouraged by seeing how others progress; and the support—and breaks—for both patients and relatives may prevent a long spell in hospital or even admission in the first place. At the end of the day therapists may telephone relatives or visit homes; and relatives sometimes attend case conferences. For those with dementia day attendance is a particular boon, if their confusion is not worsened by the changes of scene.^{18 19} Day hospitals appear too to be good value for money,²⁰ though in one study patients showed little physical improvement after nine months.²¹ (In fact long ambulance journeys and delays often cut down the time available.) There is frequently a spin off for the inpatient geriatric unit: in most cases the two units are close together and share rehabilitation services,²⁰ and inpatients have access to more activities. Day hospitals moreover provide a focus for the many professionals who may be concerned with a patient. At one case conference I attended the excellent home help organiser was a valued member of the team.

The organisation and programmes of day hospitals follow various patterns.^{22 23} Many mix the severely confused and withdrawn with other patients, which is thought to help the former: but specialist psychogeriatric day hospitals also exist.²⁴ In day hospitals generally, mornings are used primarily for individual treatments and care and afternoons for more recreational and social activities such as games, exercise, music, crafts, and perhaps gardening with special adaptations. New activities help by saving painful comparisons with past performance; I saw printing, for example, being tackled by hemiplegic men. Cooking and other domestic activities are usually available, and when feasible trips to the shops on public transport are valuable.

At the same time visits to a day hospital may be stressful, especially if they mean long ambulance journeys. They are also a somewhat artificial setting for rehabilitation; and relatives and other carers, if they see little of what goes on, may undo the efforts at rehabilitation by doing for the patient what he has learnt to do for himself.²⁵ So there is much to be said for giving physiotherapy and speech and occupational therapy at home, for training in a real life context. Generally domiciliary services are sparse; but at Northwick Park Hospital, for example, there is a successful and economic home physiotherapy scheme.²⁶

Day centres, run by social services, adult education services, and voluntary organisations such as Age Concern, are intended to provide companionship and stimulation for those not needing active treatments. But the clientele in some cases is rather similar,

and an observation study found as much rehabilitation type activity in such centres as in the day hospitals studied.²⁷ In a related study day centre patients showed more improvement after nine months in scores related to self care versus dependency than did day hospital patients.²¹ Work centres (again run by social services and voluntary bodies) also provide a form of rehabilitation for the handicapped elderly, with contracts for clerical jobs, pottery, metal work, and so on that provide a small wage for the workers. Clubs such as those run by the Chest, Heart and Stroke Association also do valuable work in providing a social outlet, varied activities, and sometimes, with the help of local therapists, an element of rehabilitation.

The value of these various community facilities is clearly undermined if the caring relatives are intolerably overworked and stressed. I touched on this important subject last week (p 368). Adequate help for carers is hard to come by, but the family support and care attendant schemes of Crossroads, some local authorities, and other organisations have made a start. In addition, facilities for intermittent "respite care" for dependent people are essential.

RESIDENTIAL CARE

In old people's homes and longstay wards many of the residents could have rehabilitation to help them make the most of the capacities they have left and possibly slow down deterioration. But they may be offered no more than weekly music and movement and craft classes. There is growing interest in rehabilitation activities in both settings (to be discussed in the next article) and the trend towards staffing local authority homes with social workers should be helpful in the long run.

A study of residential homes with different proportions of very dependent people (confused or physically disabled) concluded that there was much potential for carrying out rehabilitation with the help of hospital and community health professionals.²⁸ But staff tended to be poorly qualified and conscious of the need for more training, notably in managing the social environment of the home. Training, suggested the authors, could be provided by doctors, nurses, and therapists, and should build on the potential these homes have for providing an alternative to the environment of a longstay ward. But with many heavily dependent people in a home a self care programme, for example, would take up a large slice of staff time, they point out; and "institutional" practices—doing everything for the residents—may seem the only way to survive. Around 30% of very confused residents seemed to be an acceptable limit. Although the number of confused residents appeared to be related to the amount of total inactivity and to lack of communication, staff attitudes were crucial—the way they managed the home and their ability to stimulate activity. This was important because boredom was the great enemy of the lucid residents: "All this sitting and looking you know and nothing to look at."

The effects of dependence may be far reaching. Loss of control and responsibility are obvious features of residential care. One comparative study suggested that the sense of control or predictability in just one respect (having social visits) improved physical and psychological health.²⁹ In another experiment choice in small things and increased personal responsibility in nursing home residents was linked with more alertness and participation and greater well being than was found in the comparison group.³⁰ These would seem to be important aspects of life in any setting and of rehabilitation.

A disturbing development is the ease with which someone may now move into a private "rest home" with a DHSS subsidy—and with demand rather than need as the criterion.^{31 32} One worry is that some of this money could be going perhaps towards better services to rehabilitate people and support more of them in their own homes. Another is that no assessment need be made to see whether a person could be helped to live more independently if he or she wishes. Thus assessment of prospective residents as well as monitoring of standards and more staff training for these homes is tremendously important.

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Addresses

Age Concern Bernard Sunley House, 60 Pitcairn Road, Mitcham, Surrey CR4 3LL (advice to government departments, training for voluntary workers, information and publications, focal point for over 1100 local organisations providing services for elderly)

Association to Aid the Sexual and Personal Relationships of the Disabled (SPOD) 286 Camden Road, London N7 0BJ

Association of Carers Medway House, Balfour Road, Rochester, Kent ME4 6QU

Association of Crossroads Care Attendant Schemes 94 Coton Road, Rugby, Warwickshire CV21 4NL

Good Practices in Mental Health Project 67 Kentish Town, London NW1 (local registers of interesting and innovative projects to help the psychologically distressed, including elderly people and their families, as well as those who are psychiatrically disabled)

Help the Aged 1 Sekforde Street, London EC1R 0BE (campaigning and fundraising, support of sheltered housing, publications)

National Association for Carers and their Elderly Dependents 29 Chilworth Mews, London W2 3RG

References

- Isaacs B. Rehabilitation for the elderly. *Int Rehabil Med* 1984;6:v-vi.
- Hodkinson HM. Rehabilitation of the elderly. In: *Medicine in old age*. London: British Medical Association, 1974:126-30. (Reprinted from *Br Med J* 1973;iii:526-8. New edition in press.)
- Arie T. The future for the elderly. *J Am Geriatr Soc* 1981;29:557-62.
- Isaacs B. Treatment of the "irremediable" elderly patient. In: *Medicine in old age*. London: British Medical Association, 1974:9-13. (Reprinted from *Br Med J* 1973;iii:526-8. New edition in press.)
- Mulley GP. *Practical management of stroke*. London: Croom Helm, 1985:122-32.
- Devas M. Geriatric orthopaedics. In: *Medicine in old age*. London: British Medical Association, 1974:157-62. (Reprinted from *Br Med J* 1974;ii:190-2. New edition in press.)
- Marston P, Gallannaugh C. Clinical manager at large. *Health and Social Service Journal* 1981;May 22:603-5.
- Department of Health and Social Security. *Orthopaedic services: waiting time for out-patient appointments and in-patient treatment*. London: HMSO, 1981:34-5.
- Boyd RV, Compton E, Hawthorne J, Kemm JR. Orthogeriatric rehabilitation ward in Nottingham: a preliminary report. *Br Med J* 1982;285:937-8.
- Andrews K, Brocklehurst JC. Provision of remedial therapists in geriatric medicine. *Br Med J* 1984;289:661.
- Cosin LZ. New concepts on rehabilitation for the disabled and elderly patient. *Rehabilitation* 1975;No 95:13-7.
- Darnbrough A, Kinrade D. *Directory for the disabled*. 4th ed. Cambridge: Woodhead-Faulkner, 1984.
- Jay P. *Help yourselves: a handbook for hemiplegics*. 3rd ed. Hornchurch: Ian Henry, 1979. (New edition in preparation.)
- Buck K, Hibberd A. *The handicapped in the community* (OUTSET survey). North Tyneside Social Services Department, 1982:35.
- Wolff HS. Tools for living—a personal view of new status for aids for the disabled in society. *J Biomed Engng* 1981;3:329-30.
- Bray J, Wright S, eds. *The use of technology in the care of the elderly and the disabled*. London: Frances Pinter (for the Commission of the European Communities), 1980:xi.
- Jay P. *Coping with disability*. 2nd ed. London: Disabled Living Foundation, 1984.
- Arie T. Dementia in the elderly: management. In: *Medicine in old age*. London: British Medical Association, 1974: 104-11. (Reprinted from *Br Med J* 1973;iv:602-4. New edition in press.)
- Arie T. Day care in geriatric psychiatry. *Gerontol Clin* 1975;17:31-9.
- Irvine RE. Geriatric day hospitals: present trends. *Health Trends* 1980;12:68-71.
- Macdonald AJD, Mann AH, Jenkins R, Richard L, Godlove C, Rodwell G. An attempt to determine the impact of four types of care upon the elderly in London by the study of matched groups. *Psychol Med* 1982;12:193-200.
- Brocklehurst JC. *The geriatric day hospital*. London: King Edward's Hospital Fund for London, 1970.
- Irvine RE. Physiotherapy and the geriatric day hospital. *Physiotherapy* 1969;55:352-7.
- Peace SM. Review of day-hospital provision in psychogeriatrics. *Health Trends* 1982;14:92-5.
- Andrews K, Stewart J. Stroke recovery: he can but does he? *Rheumatol Rehabil* 1979;18:43-8.
- Glossop ES, Smith DS. *Help for the disabled and their families. A domiciliary physiotherapy research project: 1976-1978*. Harrow: Northwick Park Hospital and Clinical Research Centre Rehabilitation Department, 1979. (A report to the Department of Health and Social Security.)
- Godlove C, Richard L, Rodwell G. *Time for action: an observation study of elderly people in four different care environments*. Sheffield: Joint Unit for Social Services Research, 1982.
- Wilkin D, Hughes B, Jolley D. The implications of managing confused and disabled people in non-specialist residential homes for the elderly. *Health Trends* 1982;14:96-100.
- Schulz R. Effects of control and predictability on the physical and psychological well being of the institutionalized aged. *J Pers Soc Psychol* 1976;5:563-73.
- Langer EJ, Rodin J. The effects of choice and enhanced personal responsibility for the aged: a field experiment in an institutional setting. *J Pers Soc Psychol* 1976;34:191-8.
- Andrews K. Private rest homes in the care of the elderly. *Br Med J* 1984;288:1518-20.
- Godber C. Private rest homes: answers needed. *Br Med J* 1984;288:1473-4.