Deconditioning - What are we doing in Wales?

"No longer just a hospital issue"

Policy response:

National Rehab Framework - Health and social care services rehabilitation framework | GOV.WALES

6 goals- new hospital guidance: Six Goals for Urgent and Emergency Care - Primary Care One (nhs.wales)

Frailty Policy Position – a quality statement is currently in development

Reablement and Rehab policy position in development

Steady on Stay Safe Campaign – Welsh National Falls Prevention Taskforce in Conjunction with NHS Health boards and 3rd sector partners

DECONDITIONING IN DEMENTIA

Julia Clayton

A MULTIFACTORIAL PROBLEM

- Prolonged Bed Rest.
- Inadequate Nutrition.
- Further Reduced mobility due to inactivity, leading to Risk Of Falls
- Constipation/Incontinence.
- Confusion/Disorientation/Sensory Impairment.
- Communication/Swallowing difficulties.
- Polypharmacy.

THE ACUTE SETTING

- Relaunch of The Butterfly Scheme.
- Completing This Is Me Documents.
- Dementia Support Workers (DSW).
- Joint Working with Therapists.
- #EndPJParalysis

DEMENTIA SUPPORT WORKERS (DSW)

- Working with Dementia Improvement Team to outline and develop role of the Dementia Support Worker on the Ward.
- Ensuring DSW have the facilities to engage with patients effectively.
- Engaging patients in activities which offer stimulation, promote socialisation/group activity/daily routine.
- Working with Therapists on the ward to help run exercise/relaxation classes

IN THE COMMUNITY

- AHP Dementia Team
  - Physiotherapists
  - Occupational Therapists
  - Dietitians
  - Speech and Language Therapists

    - Working with:
      - Community Psychiatric Nurses
      - Psychiatrists
      - Consultants
      - 3rd Sector Services

AHP DEMENTIA TEAM –
A COMMUNITY APPROACH

- Working with Memory Service for referral at Diagnosis or during diagnostic process, assessments from Occupational Therapy, Physiotherapy, Speech and Language Therapy contributing to diagnosis.

- Providing information/Input from a team Allied Health Professionals to educate patients and their families and carers about the patients journey with dementia and preventing Carer Burn Out.

- Being Proactive in treating individuals with the view to pre-habilitate prior to deterioration of condition rather than being reactive.

AHP DEMENTIA TEAM –
A COMMUNITY APPROACH

- Physiotherapist- Mobility assessments/aids, resistance exercises/balance programmes, house adaptations, onward referral to 3rd sector schemes/groups.
- Occupational Therapists- Meaningful Activity, Life story work, functional assessments, house/home adaptations, enabling equipment.
- Speech and Language Therapist- Communications strategies for patients/family members/carers, Dysphagia/swallow assessments.
- Dietetics – Providing advice on oral intake, promoting appropriate foods, managing diabetes/weight gain/weight loss, food for mood, food preference changes.

CASE STUDY.

- 91 year old male.
- Under assessment with memory service.
- Reduced mobility and exercise tolerance due to isolation during Pandemic.
- Lost motivation to socialise.
- Reduced function upper limbs from past clavicle fractures.
- On assessment had communication difficulties
- Falls assessment = Low risk.

CASE STUDY.

- Exercises programme focussing on resistance exercises with upper limb rotator cuff work included.
- Regular mobility with technical instructor inside and outside.
- Referral within team to Speech and language.

- Patient now has full range of movement in both upper limbs, mobilising regularly with his wife into town to meet family and friends.
- Input from SLT has enabled patient to reconnect with family and friends with ongoing strategies so patient isn't isolated due to poor communication.
- Onward referral to 3rd sector groups/schemes has been discussed for ongoing input.