Rehabilitation:
What’s new?

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Plan

1. Focus and structure
2. Content, a few key recommendations
3. What hasn’t changed, but really should
Let’s start with some clarity...

• What does the ICSWP mean by rehabilitation?
• When should it happen?

‘A process aimed at enabling people with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels’

Rehab is not JUST therapy
Rehab is not just for Christmas
What’s new for rehabilitation?

Structure, emphasis, completeness, reducing inequalities:

Focus - patient-centred, pathway, care home residents

Positioning - ‘rehabilitation’ moved from chap 6 to chap 4

Chap 4 - problem-based, A-Z from ADLs to Vision
- from 46 to 17 topics, from 44 to 35 pages

Completeness of topics -
- Introduction
- Evidence to recommendations
- Recommendations
- Sources
- Implications (collective)
A suite of guideline documents

Full guideline

Easy read

Concise guideline
Some of the concise guidelines

Key recommendations for stroke 2016

This concise guide contains only those recommendations that have been identified as being critical by the Royal College of Physicians. The recommendations are intended to provide guidance on the management of stroke and its complications. The guidance is based on the latest available evidence and is intended to be used in conjunction with the full guidelines, which are available from the Royal College of Physicians website.

Overall structure of stroke services

Commissions of acute stroke services

Commissioning acute stroke services

Commissions of acute stroke services

Orthoptics concise guide for stroke 2016

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Transfers of care from hospital to home

Rehabilitation approach - intensity of therapy

Psychological care - organisation and delivery

Early mobilisation

Activities of daily living

OCCUPATIONAL THERAPY CONSCIOUS GUIDE FOR STROKE 2016

This profession specific concise guide contains recommendations derived from the National Occupational Therapy Guide for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. The reference number of each recommendation is provided so that they can be found in the guideline (www.nice.org.uk). This concise guide should not be used in isolation, and it should be used in conjunction with the full guideline.

Transfers of care from hospital to home

Rehabilitation approach - intensity of therapy

Psychological care - organisation and delivery

Early mobilisation

Activities of daily living
What’s new in 2016 – 9 topics

1. thrombectomy
2. imaging
3. blood pressure in ICH
4. minor & TIA management
5. psychology
6. early mobilisation
7. end of life care
8. gait training for people unable to walk
9. BP targets for 2° stroke prevention
1) Commissioning rehab 6.4.1A
2) Overall service 6.1.1A
3) Transfers of care 2.7.1A & K
4) Work and leisure 4.1.4.1B
5) Aphasia assessment 4.4.1.1A
6) Life after stroke, reviews 5.9.1.1A
7) Hydration and nutrition 4.7.1F
8) Care homes 2.17.1A
9) H/ASU resources 2.4.1B
10) Org psychological care 2.12.1A
11) Early mobilisation 3.12.1B
12) Rehab – intensity 2.11.1A

Rehabilitation in the 30 key recommendations
Resources

2.4.1B A hyperacute and/or acute stroke service should provide specialist medical, nursing, and rehabilitation staffing levels matching the recommendations in Table 2.1.

- Addition of orthoptists to MDT 2.4.1 J
- Two additions to Table 2.1
### Table 2.1 Recommended staffing levels for stroke units

<table>
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<tr>
<th></th>
<th>PT WTE/5 bed</th>
<th>OT WTE/5 bed</th>
<th>SLT WTE/5 bed</th>
<th>Psy WTE/5 beds</th>
<th>Diet WTE/5 bed</th>
<th>Nurs WTE/1 bed</th>
<th>Cons physic</th>
</tr>
</thead>
<tbody>
<tr>
<td>HASU</td>
<td>0.73</td>
<td>0.68</td>
<td>0.34</td>
<td>0.2</td>
<td>0.15</td>
<td>2.9</td>
<td>24/7, min 6 rota</td>
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<tr>
<td>ASU</td>
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<td>0.81</td>
<td>0.40</td>
<td>0.2</td>
<td>0.15</td>
<td>1.35</td>
<td>5 days ward rounds</td>
</tr>
</tbody>
</table>

**Implications** - “require a considerable increase in the provision of some specialties in stroke services, especially clinical/neuro-psychology...”.
Psychological care – organisation and delivery

2.12.1A Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical neuropsychology/clinical psychology input within the multi-disciplinary team.
2012 Early mobilisation 4.15.1B
People with acute stroke should be mobilised within 24 hours of stroke onset, unless medically unstable, by an appropriately trained healthcare professional with access to appropriate equipment.

2016 Early mobilisation 3.12.1B
Patients with difficulty moving early after stroke who are medically stable should be offered frequent, short daily mobilisations (sitting out of bed, standing or walking) by appropriately trained staff with access to appropriate equipment, typically beginning between 24 and 48 hours of stroke onset. Mobilisation within 24 hours of onset should only be for patients who require little or no assistance to mobilise.
What’s NOT new, but should be

• general cognition “little research”
• apraxia “absence of new evidence”
• attention & memory “only 1 of sufficient quality”
• executive function & neglect “insufficient”
• perception “uncertainty”
• anxiety, depression & distress “more needed”
• Emotionalism “not changed”
What’s NOT new, but should be

• Not just psychology - Also evidence gaps in communication, continence, driving, fatigue, mental capacity, pain, sex, work, carers, self management, life after stroke..........

• Need plan of action – growing capacity & collaborative culture

• Need (sensible) NIHR commissioned calls
What’s new in rehabilitation?

The short answer – a lot

The good news
• great teamwork ➔ patient-centred focus
• great teamwork ➔ consensus
• high quality evidence ➔ definite recommendations

Thank you

The bad news
• evidence may be difficult to accept
• worrying absence of activity in some topics