Taking Care!

Regaining Strength… Recovering From A Health Crisis Takes A Team

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If you or a person you are caring for becomes hospitalized due to a health crisis - such as stroke, a hip fracture or prolonged acute illness - an inpatient rehabilitation program may be recommended. Rehab may occur onsite or at an acute rehabilitation facility or skilled nursing home.

The goal of rehab is to help people who have experienced health setbacks regain their strength and endurance. The focus is on reducing disability and, where permanent disability remains, managing it in the best possible way.

Rehab programs may be general or specific to a certain type of injury or diagnosis, such as stroke. They vary in intensity and duration, some being time-limited while others allow the patient to continue as long as progress is being made.

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Typical criteria for acceptance into a program include medical stability; physical potential for improvement; mental ability (including sufficient attention span and memory) to participate in therapy; and willingness to participate in the program and try new ways of doing things, including using adaptive aids (such as walkers or wheelchairs) if necessary.

Upon admission, staff assesses a patient's abilities and limitations in order to develop an individualized care plan involving measurable goals and plans. Treatment usually includes individual and group therapies.

Challenges patients may face during rehab include having to conform to a tight schedule; fatigue, especially if they are unaccustomed to physical activity; embarrassment at having to re-learn basic activities such as washing and dressing; and frustration from unrealistic expectations. Moreover, progress may be impeded by medical conditions such as clinical depression, impaired cognitive function, pain, medication side effects (drowsiness, for instance), or concomitant illnesses or chronic conditions.

Patient progress is evaluated on an ongoing basis. Evaluation also occurs formally through frequent team meetings and periodic review conferences that include the patient and family. Staff adjusts goals and plans as needed and monitors patient readiness for discharge.

Service is delivered by a team of health care professionals who consult and collaborate on a continual basis, ensuring a coordinated, holistic approach to assessment and treatment. Following is an overview of each member's role.

- **Case Manager** - Team leader, responsible for overall planning, coordinating care and evaluating outcomes.
- **Physician** - Diagnoses and treats medical problems, ordering investigations and treatments and consulting with specialists as needed.
- **Nursing Staff** - Assess health status, administer medication and other physician-ordered treatments and assist with personal care as needed.
- **Physical Therapist (PT)** – Evaluates patients' functional ability and works with them to improve or maintain walking, balance, endurance, strength and flexibility.
- **Occupational Therapist (OT)** – Teaches alternative ways of carrying out daily activities, including self-care skills and homemaking tasks. Performs home evaluations, recommending adaptations and special equipment to maximize safety.
- **Dietitian** - Evaluates nutritional status and recommends necessary dietary changes to help treat diet-related health problems, such as constipation.
- **Speech** - Language Pathologist (SLP) - Assesses and treats difficulties related to hearing, speech, language and swallowing.
- **Social Worker** - Helps patients and their families learn how to cope more effectively with losses, emotional issues, family problems and financial concerns, and links them with community resources.
- **Recreation Therapist** - Fosters quality of life by providing opportunities for fun, creativity, socialization and learning.
- Together the various disciplines work with each patient to help them achieve the highest possible level of health, independence and quality of life.

For those returning home, a graduated discharge is encouraged, beginning with daytime visits and progressing to overnight stays of increasing length. These temporary leaves of absence help the patient, family and team to determine if special services or further home alterations are required (and sometimes if returning home to live is even feasible). Referral may be made to an outpatient rehab program or to home care physical or occupational therapy if some therapeutic goals remain, or as a transitional measure.

If discharge to home isn't possible, the patient and family are provided with information on appropriate residential care facilities and given an opportunity to tour them. One or more selections are then made, depending on whether or not there's a waiting list.

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