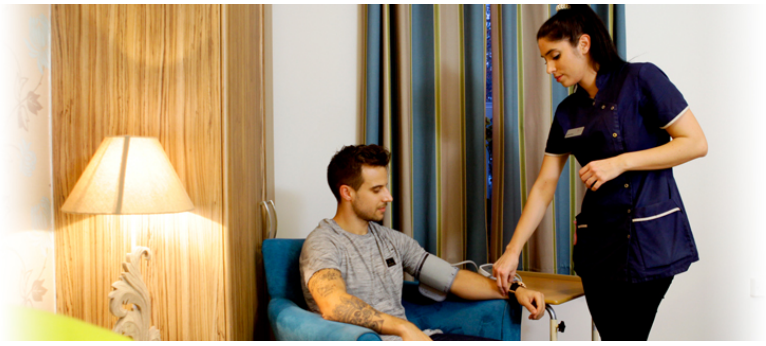
Ascot Rehabilitation



Quality Report 2016

A Message from the CEO

2016 has seen our facilities grow from strength to strength with the development of new roles and services to ensure quality of care to our patients and excellent support for their families. We continue to stay true to our vision: recovery through excellence.

This Quality report presents our achievements in terms of clinical excellence, effectiveness, safety and patient experience. It demonstrates that all staff members at Ascot Rehabilitation are wholly committed to providing continuous, quality care to every patient we treat.

The experience that patients have in our hospital is of the utmost importance to us and we are committed to establishing an organisational culture that places patients at the heart of everything we do. We pride ourselves on the lengths we go to, ensuring that patients and their families remain our primary focus throughout their care with us, and indeed long after. Building on the popular initiatives of 2015, we launched various activities for patients including art, music and poetry lessons, and we are looking to widen that variety throughout the coming months and years.

We aim to keep developing our initiatives around quality and safety to ensure we are able to bring further benefits to our patients through the care they receive.

This year has seen significant and notable improvements to our services including new projects, roles and therapy initiatives. Our focus on continual improvement enables us to provide a world-class service to our patients as we prepare ourselves to head in to 2017.

Contents

Introduction

In the 5 years since we have opened we have gone from strength to strength. We were delighted this year to have become accredited by Comparative Health Knowledge Systems (CHKs), a leading provider of health care intelligence and quality improvement which benchmarks against large providers of healthcare.

Our aim is for our patients and their families to experience an expert personalised experience. CHKs, and the ISO accreditation that is achieved alongside it, demonstrates our commitment to quality. Our main aim is to work with our patients on what is important to them – their aspirations and their goals – to ready them for the next stage of their journey after they leave our care.

We provide bespoke inpatient, outpatient and outreach programmes for people, ensuring a whole team approach around the patient, their family and their needs. This year has seen steady growth in our outreach services in supporting more people towards independent and supported living in the community, as well as training the care teams who are looking after the needs of these patients. We aim to screen all patients before they come to us in order to create a bespoke package to enable that person to meet their full rehab potential.

Each patient is allocated a keyworker as the main contact person for the patient and, often more importantly, for the family. They meet formally with the patient and/or the family once a week to talk through any concerns or issues, as well answer any questions and help explain how our rehab teams are working as a coordinated unit to achieve their goals.

Therapy at Ascot is delivered 6 days a week, but we see the whole care cycle as a continuous and ongoing form of rehabilitation that never stops, 24 hours a day, 7 days a week. The most important thing to us are our patients and their families. They are at the forefront of everything we do, and we work hard to get the best possible outcomes for them in every instance.

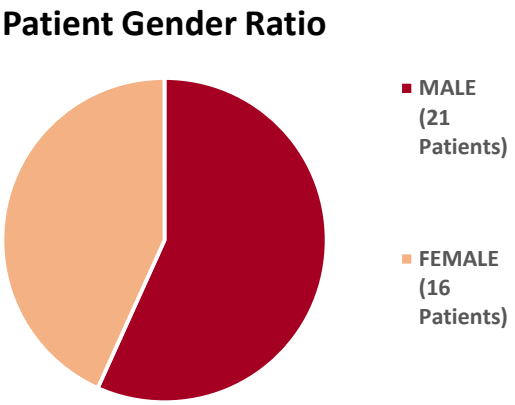
It is a privilege to work among such an enthusiastic and professional group of people.

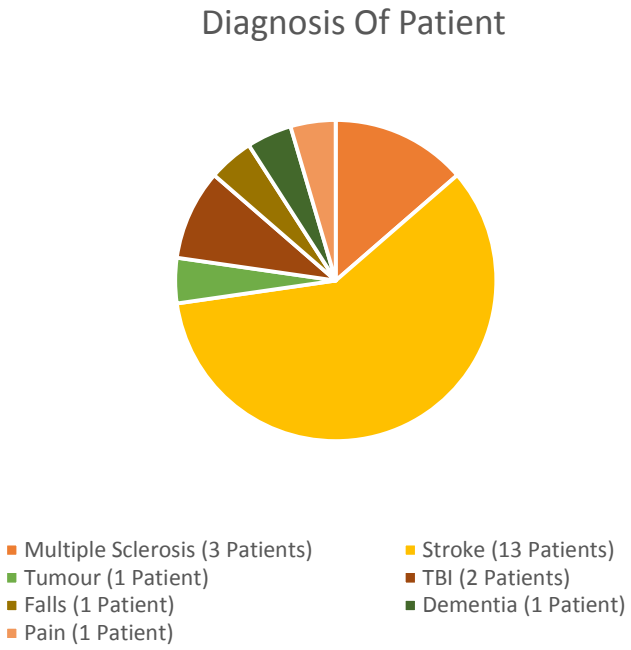
Louise Turpin

General Manager and Head of Rehabilitation

Our Outcomes

- **37 patients** were admitted in 2016
- The **average age** of inpatients was **60**
- The average length of stay was **9 weeks.**
- The average waiting time between preadmission assessment to admission was **3 days**





Outcome Measure Statistics

Outcome measurement is used to plot the progress of an individual through rehabilitation and/or to describe the success or otherwise of a service. These are very different tasks but the conventional approach is to choose a selection of individual measures that cover a number of domains and to use the means of the calculated scores for all patients to assess the service. We followed this process in choosing our outcome measures.

Having considered the range of measures we selected measures which we hoped would cover a broad range of domains and which were measures that could cope with a heterogeneous group of patients. As a small service with a very broad remit, this is particularly challenging for Ascot Rehabilitation. Our service accepts people in low awareness states through to people returning to work. In addition we work with groups with acquired brain injuries including TBI, stroke, tumour and other neurological illness as well as those with degenerative disorders and spinal injury patients. As a consequence the scores that we collect on any series of measures applied to all our clients have a high degree of variability.

Ascot Rehab uses numerous measures per discipline for our patients. We also use unit-wide outcome measures. The unit-wide outcomes we use are:

- The UK FIM/FAM
- The Care and Needs Scale (CANS)

In 2015 we had also used the Mayo-Portland Adaptability Index (MPAI-4) and the St Andrews-Swansea Neurobehavioural Outcomes Scale (SASNOS) as unit-wide measures, but we found that these did not capture any significant statistical data due to the huge variability of the patient's diagnosis, level of disability, demographics and a range of other factors. It was decided to discontinue those outcome measures in 2016 and we hope to utilise more appropriate measures in future that can adequately reflect the work we are doing.

UK FIM/FAM

The Functional Independence Measure or FIM is an 18-item, seven level ordinal scale. It is the product of an effort to resolve the long-standing problem of lack of uniform measurement and data on disability and rehabilitation outcomes. It was intended to be sensitive to change in an individual over the course of a comprehensive inpatient medical rehabilitation program. It was designed to assess areas of dysfunction in activities which commonly occur in individuals with any progressive, reversible or fixed neurologic, musculoskeletal and other disorders. One limitation relative to using the FIM in evaluating survivors of TBI is that it is not diagnosis specific. Although found to be reliable and valid, the scale has few cognitive, behavioural, and communication related functional items relevant to assessing persons with TBI.

The Functional Assessment Measure or FAM was developed as an adjunct to the FIM to specifically address the major functional areas that are relatively less emphasized in the FIM, including cognitive, behavioural, communication and community functioning measures. The FAM consists of 12 items. These items do not stand alone, but are intended to be added to the 18 items of the FIM. The total 30 item scale combination is referred to as the FIM+FAM. In the UK version further work was done to provide clearer definitions of the FAM scale. The FIM has good psychometric properties but the FAM remains weak in psychometric terms and many rehabilitation professionals do not agree with the scaling. Despite these misgivings we chose to include the FIM/FAM as one of our measures at Ascot because it is so widely used and as such may allow for some comparison between Ascot and other rehabilitation settings.

Initial data from UK FIM/FAM

18 patients were admitted in 2016 with admission and discharge FIM + FAM outcomes completed. We have not created splat charts (the recommended way to illustrate change on FIM/FAM) averaged across these 18 patients as the level of variability is simply too high. Figure 1 below illustrates the cumulative total FIM/FAM scores on admission and discharge, and Figure 2 illustrates the mean change per patient on FIM/FAM from admission to discharge. Higher scores represent improvement.

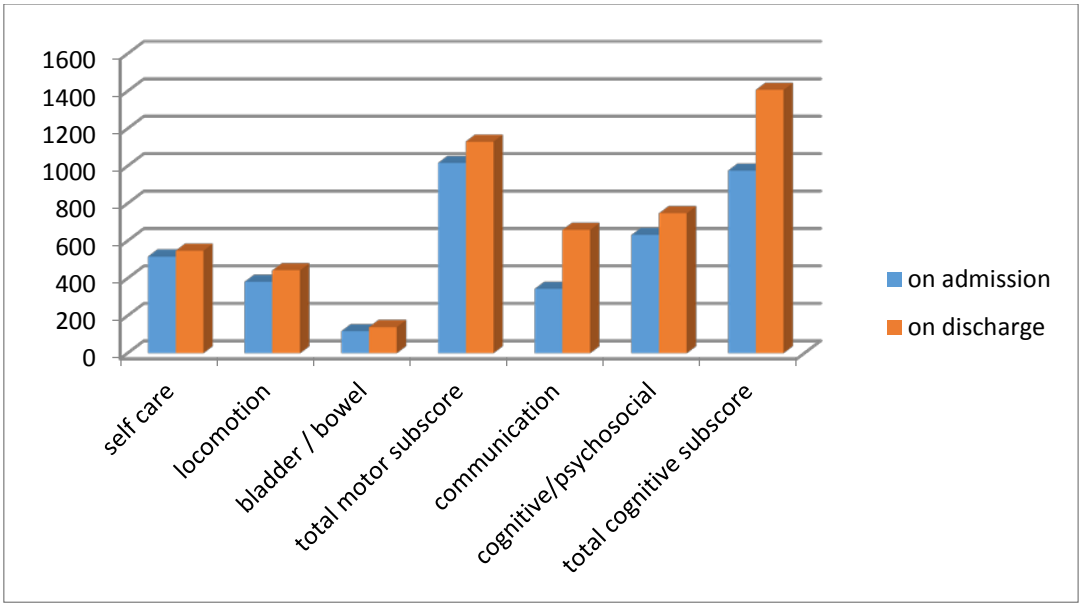


Figure 1. Cumulative total FIM/FAM scores for all 18 patients on admission and discharge

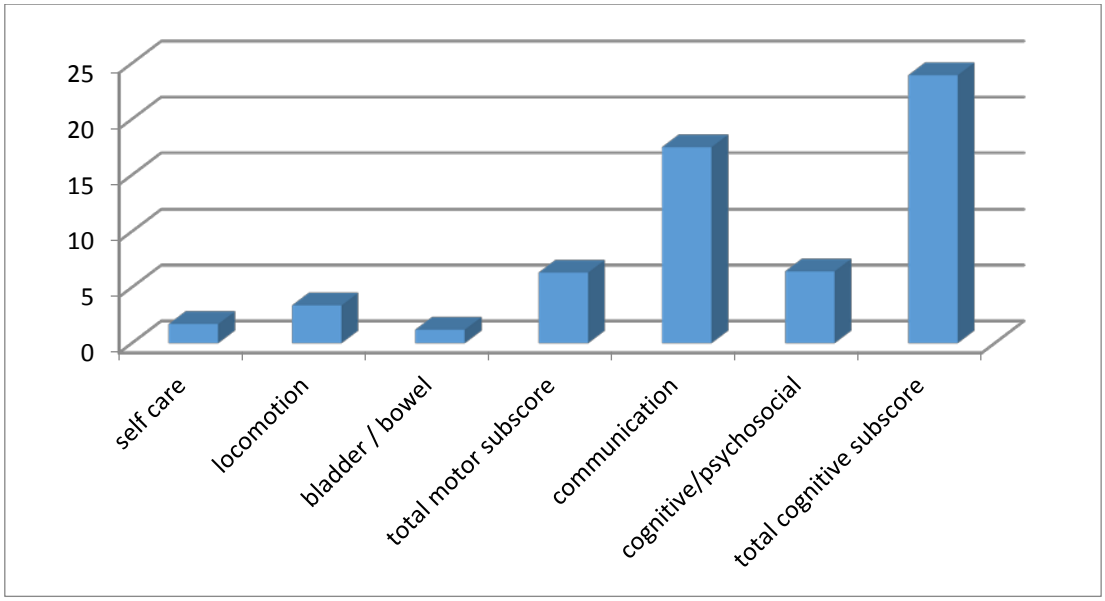


Figure 2. Mean change per patient on FIM/FAM subscales during admission

Paired-samples t-tests were conducted to compare FIM/FAM scores for each patient on admission and on discharge for the total motor subscore and the total cognitive subscore.

There was a significant difference between FIM/FAM scores on admission compared to FIM/FAM scores on discharge for both the motor subscore (t=2.28, p=0.04) and the cognitive subscore (t=3.39, p=0.001).

These results indicate that there is a significant increase in FIM/FAM scores for patients at Ascot Rehab during their admission on both the motor subscale and the cognitive subscale of the FIM+FAM. This shows that patients at Ascot Rehab significantly improve their levels of functioning as assessed by the FIM/FAM during inpatient stay at Ascot Rehab.

Care And Needs Scale (CANS)

Cans is an 8 level categorical scale designed to measure the level of support needs of older adolescents and adults with traumatic brain injury. Suitable for people over age 16, it is designed for use by professionals within a rehabilitation setting. It comprises two sections, a Needs Checklist and Support Levels. It has very good psychometric properties.

In terms of the two CANS measures, the type of care needed (needs checklist) and the length of time that someone can be left alone (support level) were calculated for 21 patients at admission and discharge.

In terms of the needs that our patients had, 2 patients changed the type of care needed, which represented a significant improvement in their abilities and needs. 19 patients remained unchanged in the type of care they needed.

In terms of the level of support that they required, 14 people had no change, five reduced the amount of support they required and 2 increased the amount of support.

Outcomes Summary

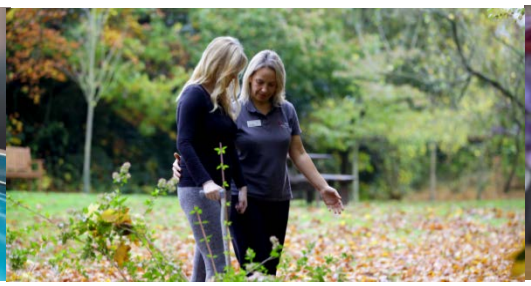
The great degree of variability makes it very difficult to conduct any significant statistical analysis of the data. On a top-line level, patients have clearly improved in their motor and cognitive abilities as measured by the FIM/FAM scale. There is a general improvement in the patient's scores in the outcomes that we measure and this trend is encouraging.

The difficulty in analysing the data that we do capture is multifaceted. Our patients present with a hugely varying set of diagnoses and level of disability; the diversity in age and ethnicity, for example, is great; and the length of stay can range from days to years. There is no typical patient with regards to diagnosis, demographic or rehabilitation goals. This becomes an issue only for data gathering and presentation, as there does not currently exist an outcome measure that can adequately capture such data. The nature of a rehabilitation programme constructed for a patient staying for three weeks will be very different than for a person staying upwards of six months and the level of supervision of an individual in a long-term low awareness state is unlikely to change.

Going forward in the years ahead, we hope to be able to use a variety of measures that are better able to capture and reflect the progress of every patient. As our numbers grow, we plan to make use of outcome measures on subgroups of patients that are practical and relevant, and that will allow us to benchmark our performance and results against a wider area.

The Patient Experience

We believe in a philosophy whereby we ‘do living’ rather than ‘do rehab’. That means we aim to make every patient feel the benefits of our therapy and care teams, but also of our hospitality staff. Guests stay in en-suite rooms with satellite TV’s; are catered for by our on-site chefs using quality ingredients; and have access to a range of activities like music therapy sessions, art classes, and tai-chi. We have on-site interpreters to cater for international patients and a dedicated team to provide a chauffeur service for patients and their families during their stay. In creating a harmonious environment where patients can feel content and families reassured, we pave the way for a quality delivery of service and successful outcomes.



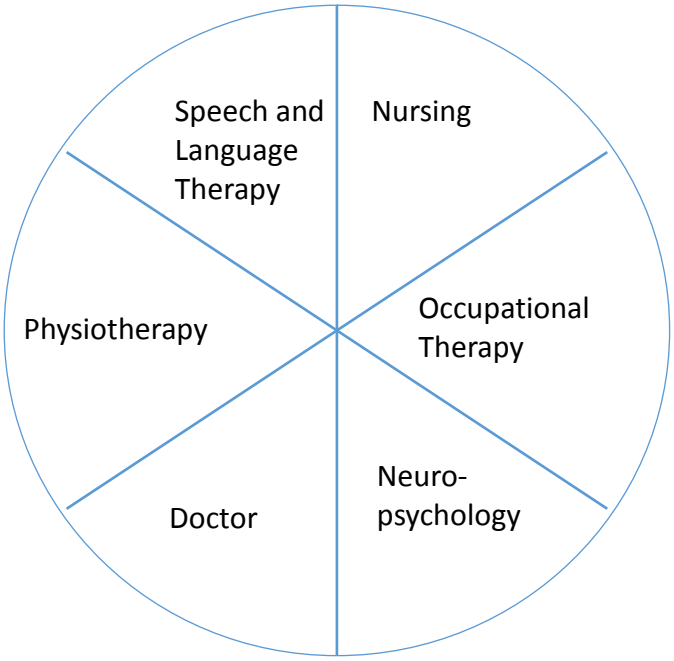
Patient Feedback

We feel that we can always improve on what we are doing and we actively encourage our patients to express their thoughts and feelings with regards to the service that we provide. We welcome negative feedback and criticism as an opportunity to perfect what we strive for, namely a caring and constructive form of intensive rehabilitation.

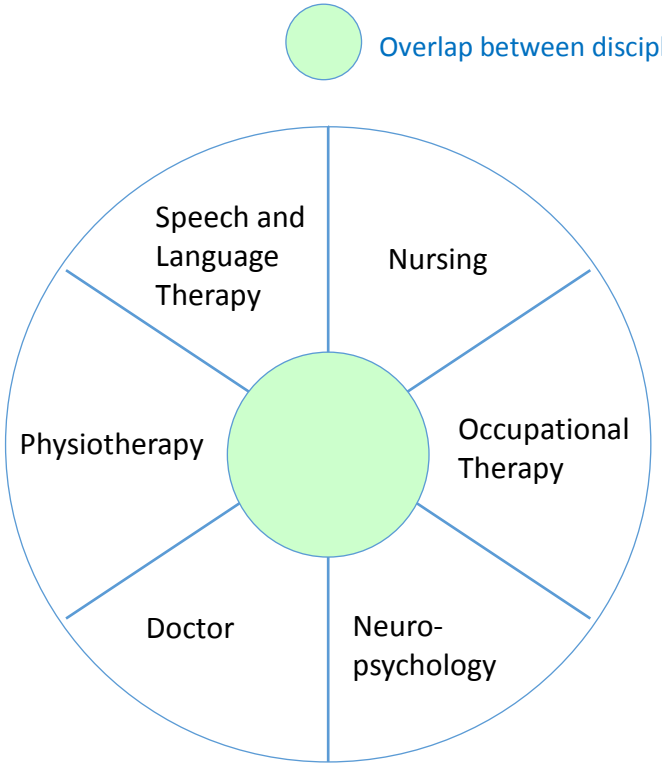
That being said, our patients give us overwhelming praise for what we do. Below is a snapshot of what our patients had to say in 2016 using the official feedback process. All numbers are based on actual patient surveys throughout 2016 where answers were provided:

Our Transdisciplinary Model

In traditional Multi-Disciplinary Teams (MDT's), different sessions occur sequentially and involve the application of an intervention by one profession. A patient might see a physiotherapist followed by an occupational therapist. Appointments with different disciplines tend to be independent of each other, although there are referrals between.

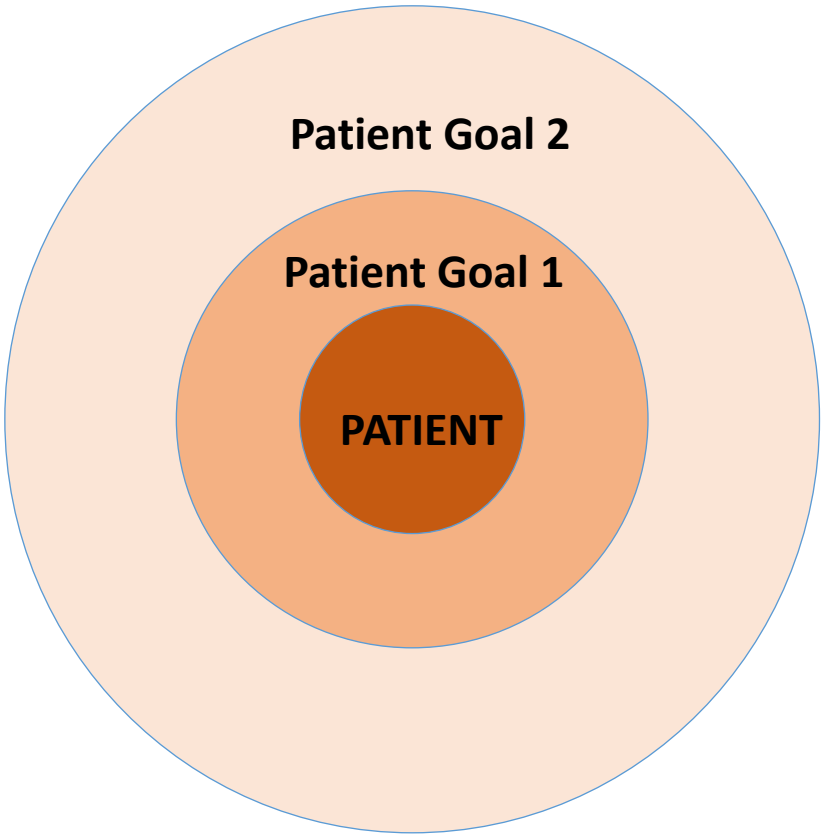


Traditional Multi-Disciplinary Model



The Inter-Disciplinary Model

With the Transdisciplinary model at Ascot Rehab, we strive for a process rather than an intervention. It demands teamwork to bring about gradual change. It is not the application of a series of procedures but an integration of strategies across the 24 hour period. The old mantra of 'Patient First' really comes to life here in a transformative synthesis of disciplines.



The Trans-Disciplinary Model

The benefits of our Transdisciplinary approach are numerous and significant. There is a consistency and continuity in the 24 hour care which means things do not fall through the net. We work with the whole family to structure the day beyond therapy, to create a functional platform to work on goals.

Our Awards

We are very proud to have been recognised in 2016 for our consistency in delivering high-quality healthcare. By achieving both CHKS and ISO accreditation, we are showing that we constantly maintain focus on the systems and practices that lead to better patient outcomes. CHKS evaluates factors such quality standards, risk management and clinical effectiveness against international benchmarks and standards.

CHKS accreditation is a recognition that there are practical and rigorous quality control processes that drive continuous improvement in both patient care and management. Staff are encouraged to have a sense of ownership and are consequently empowered to effect meaningful change. When staff were asked, in the 2016 Staff Survey, if they feel they are involved in the development of service, over 90% responded that they were. This synthesis of consultants, therapists, care staff and management is the cornerstone of our philosophy to help build a better future for our patients.

Advances In Rehabilitation

We not only have world-class professionals but state-of-the-art technology to enable the full potential of rehabilitation. Our therapists have access to a wide range of specialised gadgets, giving them a huge range of options when devising the best plan for patients. In keeping up to date with advances in technology, we are keeping at the forefront of rehabilitation.

Our technological aids include:

The Biodex Gait Trainer 3 and accompanying unweighing system

Fiberoptic Endoscopic Evaluation of Swallowing

Alter G Bionic leg system, with Sent Cam.

Bioness H200 Functional Electrical Stimulation System

Bioness L300 Functional Electrical Stimulation System

Case Study

Whilst working in Australia as a tree surgeon, Tom suffered fractures and severe head injuries when a tree he was working on accidentally fell. A neurology specialist case management company referred him to Ascot Rehab and Tom returned to England. Tom is happy for us to share his story and progress, in the knowledge it will offer others like himself real hope for the future.

ADMISSION DATE: September 2014:

Mobility: Unable to self-propel wheelchair. Transferred with minimum assistance of one person.

Diet and swallowing: Thick pureed diet. Profuse drooling. PEG fed.

Communication: Severe dysarthria (difficulty speaking caused by problems controlling the muscles used in speech) characterised by reduced breath support, reduced range of movement and weakness of the tongue. Evidence of mild dyspraxia (difficulty in activities requiring coordination and movement). Mainly non-verbal with occasional automatic utterances. Low intelligibility. Low motivation to engage in speaking. Communicated using Grid 2 app on Windows tablet. Decreased awareness of appropriate social interaction with females.

Personal ADLs (Activities of Daily Living): Incontinent of bladder and bowels, day and night. Assistance of one person required to turn in bed at night, shower and dress.

Community access: With assistance of two therapists and a family member once a week.

Cognition: Evidence of posttraumatic amnesia characterised by repetitive questioning; moderate behavioural disinhibition.

Since his admission Tom has participated in an intensive rehabilitation package. Initially, due to his post-injury fatigue, sessions ranged from 20 to 45 minutes with two rest periods per day. Currently, Tom is tolerating a full rehabilitation programme and session up to 90 minutes.

TODAY: May 2016

Tom is now independently mobile. He goes to the gym twice a week with a support worker. He is currently livening in the transitional living suite at Ascot while he waits for his own property to be built on his parent's grounds. He is on a normal diet – soft food and normal liquids. He no longer has a PEG in situ. Tom makes his own breakfast each day with minimal supervision.

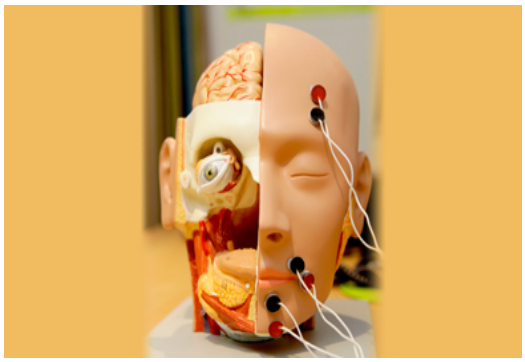
Tom has been through a course of LSVT LOUD™ and now communicates all his needs verbally and is able to carry out a conversation. He is continent and independent with all his toileting needs. He attends all timetabled therapy sessions and engages purposefully in emotional adjustment counselling, which involves reflections about his long-term future.

Tom will return home to his own living conditions soon and therapy is now focussing on his long terms plans to manage his own life and engage back into voluntary or work related activity. He will have care support during the day but be independent with his own night time care.

Our Future

We are building on our key strengths in 2017 by maintaining a patient-centred focus through coordinated service delivery. Hospitality, care and therapy teams will continue to work in tandem to achieve the common goal of patient rehabilitation through high quality care. We will continue to invest in our people and our facilities to enable us to deliver our vision:

To be the leading centre of excellence in rehabilitation services, providing the highest quality of Rehabilitation and care to our patients.



We strive to actively participate and engage in academic research and conferences that intuit a new way forward in neurological care. By keeping at the forefront of their respective fields, our consultants and therapists are able to maximise the impact of the high-intensity rehabilitation that we offer. No stone is left unturned in the quest for better patient outcomes.

Following our CHKS accreditation in 2016, we will look to gain further accreditation that recognises the value of the work that we are doing. Patients and their families can rest assured that they will be receiving the best possible care in light of independent audits and evaluations

Finally, we will continue to seek feedback from consultants, insurance companies, embassies and, most importantly, from our patients. We plan to introduce more relevant activities to keep patients occupied in a constructive way to complement the existing opportunities to engage in art and music classes, for example.