REHABILITATION

at Mount Carmel Hospital and in the Community

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What is Rehabilitation?

Rehabilitation is the process through which a person is helped to adjust to the limitations of his disability. Lost skills may be regained and coping strategies developed.

The aim of the rehab team is to restore the individual to his maximum level of independence, psychologically, socially, physically and economically.

Rehabilitation Programme

Any rehabilitation programme must be based on:
1. Assessment of the individual's skills and limitations so that realistic goals may be defined.
2. Appropriate treatment programme devised.
3. Reassessment and evaluation leading to modification of the programme.
4. Achievement of a gal allows termination of no particular part of the programme or a change on emphasis.

Rehabilitation programmes should be rehabilitative rather than designed to occupy the patient.

Principles of Rehabilitations

Four basic principles:

1. Listen to the patient
2. Know the community
3. Pay attention to detail
4. Remember how the world have changed

Rehabilitation Programme

Rehabilitation programmes consist of 3 stages.

1st. Stage - Rehabilitation within the hospital. Patients from admission wards are transferred to the long stay wards 5A, 5B, 3A, 3B or directly to Half-Way House.

Patients from Chronic long stay wards are assessed and reviewed regularly after they are either:
1. Referred to another Dept.
2. Transferred to HWH
3. Discharged home

2nd. Stage - Bridging the gap i.e. resettlement in the community.

The rehab process does not end at this stage but it is intensified as the patient comes face to face with the realities and problems of life in the community. While for some discharge will be a realisation aim, for others more independent level of living within the hospital may be the appropriate goal. It is at this point where a need for Hostels within the hospital is felt.

3rd Stage - Community Support

1. Home visits
2. Wednesday groups

OT involvement in the rehab programme

1. Selection of clients for training
2. Identifying the areas where individual training needs to be given.
3. Selecting what eventual placement might be suitable, i.e.
   A. Transfer to another department
   B. Accommodation in the Community
   C. Transfer to another rehab unit such as HWH.

OT long Term Goals

are aimed at

1. Improving independence and or creating a better quality of life.
2. Adjustment outside the hospital or another institution by:
a. increasing domestic self help skills
b. improving social and interpersonal relationships
c. Purposeful use of recreational time

Observed Problems

1. Apathy and no motivation
2. Lack of self-care
3. Very poor life skills:
Domestic skills - Coping skills - Social skills
4. Resistance to change (both patients and relatives)
5. Institutionalisation
6. Social problems:
   A. Stigma
   B. Getting a job (economic problems)
   C. Finding a home
   D. Re-socialisation
   E. Difficulty in getting alone
   F. Refusal, resistance from family members, carers

G. Lack of support
H. Role changes within the family

Rehab Programme

1. Ward based domestic activities programme
2. Introduce patients to the use of knives when eating
3. Introduce the use of trays during lunch time
4. Future introduction of washing machines on these wards
5. Daily use of showers for people who wash independently
6. Provide patients with their own set of clothes and personal belongings such as toothbrush, underwear, umbrella
7. Improve the environment on the wards by putting on pictures, colourful printed curtains
8. Family involvement
9. Improve self-care
10. Social Activities - patients' involvement in organisation of parties/social functions

Difficulties Encountered

1. High number of patients
2. Lack of staff - individualised care is difficult to be offered.
3. High number of psychogeriatric patients who are fit for another ward (demented, incontinent) These interfere with the ward rehab programme.
4. Environment - non therapeutic.
5. Lack of facilities on ward - structural, material, financial
6. Resistance to change from staff
7. Role Conflicts (Rule-book mentality)
8. No continuity of care
9. Lack of community-based facilities.

Changing the system is not as simple as might first appear.

1. Firstly because people in institutions tend to resist change and even when identified, undesirable attitude might prove very difficult to the change.

2. Even where there is a desire to change, the precise change brought about might not be what one had anticipated.

THE MALTA ASSOCIATION OF OCCUPATIONAL THERAPISTS NEWS:

by Stephanie Vella, Secretary

DANCE MOVEMENT THERAPY SEMINAR - FEEDBACK

The M.A.O.T. in conjunction with the Maltese Psychological Association held the workshop in dance movement therapy headed by Ms. Nina Papadopolous. The duration per workshop was of 3 hours having 25 participants respectively. The range of participants varied from University lecturers, therapists, psychologists, special needs teachers, social workers, dancers and university students.

In the initial part of the seminar Nina introduced the participants with the theoretical framework of Dance and Movement. After a short break she indulged the participants into a hand-on experience of dance movement therapy. She used ice breaking exercises, mirroring techniques, role reversal techniques, dialogue through dance and spatial awareness exercises. During these exercises Nina used classical/contemporary music as well as jingles which help her to maintain or change the timing of how the group moves.

Nina works in various Day Centres in the United Kingdom including elderly persons, physically disabled persons, mental health persons and adults with special needs. Age does not make any difference. Also Nina works in a school for normal children. She also published atricles and carried out research studies.

Nina enjoyed working with all the participants and many of them stated that it should have been longer and that there should be a follow up of this workshop. One hope it will come through!