EUPU Leonardo Project
Derby City General Hospital, Derby, UK

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Abstract

The EUPU Leonardo da Vinci professional exchange programme affords qualified staff a sterling opportunity to gain experience in a practice setting in the EU. This paper describes one such professional practice experience in the Derby City General Hospital, Derby UK. Whilst highlighting the variety of therapeutic settings and practice opportunities which she encountered, the author attests that the range of skills Maltese occupational therapists can call upon can be applied and adapted with confidence in a number of practice milieus in the UK.

Introduction

My six-week clinical placement which took place between the 17th January and the 1st March 2004 at the Derby City General Hospital in Derby was undertaken as part of the EUPU Leonardo Project. I was placed at the adult acute general medicine Occupational Therapy (OT) section. The staff complement consisted of three Senior I Occupational Therapists, two Senior II Occupational Therapists, three Basic Grade Occupational Therapists and one Occupational Therapy Assistant. All the staff covers the different general medical wards at this hospital.

The aim of the first two weeks of this placement, was to gain a general overview of how the hospital system runs, and the occupational therapists working in the different wards were very kind to guide me through this phase. Eventually, I was working on an acute medicine ward with one of the Basic Grade therapists.

Overview of the Service Site

Derby City General Hospital is run by the Derby Hospitals NHS Trust foundation. Services provided by this hospital include: integrated medicine, surgery and urology, obstetrics and gynecology, rehabilitation, critical care, and support services.

It is evident that the health care system in the UK is very different from the one we have in Malta, therefore, as a result, the OT approach differs significantly. In the UK, the occupational therapist's role is more defined and most of the hospital staff is aware of what it entails, namely helping the patient to remain independent in self-care, leisure and domestic tasks. When possible, the patient is helped to return safely to his/her home environment with the necessary

adaptations and post-discharge care where this is indicated.

On the wards, once medically stable, the patient is referred to OT. A handover is given every morning by the nurses where the patient's presenting condition is discussed. This helps the clinicians to prioritize the patients' needs. After checking the patient's medical history, the therapist carries out an initial interview. The patient's previous level of function and performance, together with details about the physical environment of the home and any services which were being provided, are reviewed and discussed. This is followed by a functional mobility assessment (transferring from bed, chair, toilet and walking) and self-care assessments, such as washing, dressing and toileting. If necessary, a cookery assessment is carried out by the therapist or the assistant.

Turnover on the wards is quick due to an intensive focus on acute care provision. Therefore, if the occupational therapist finds that the patient might benefit from using particular aids or equipment at home, s/he is assessed using these on the ward or at the department and they are provided before discharge. Where possible, the patient's relatives or carers are notified of the patient's progress and about any equipment which might be needed after discharge. If equipment, such as a toilet-seat raise or a bath-board, need to be used, the occupational therapy assistant is assigned to go to the patient's house to ensure that they are installed properly.

Most of the wards use a team approach and the patient is treated holistically. The team includes the consultant, senior house officer, junior doctor, nurse, physiotherapist, occupational therapist and where necessary, the care manager, social worker and speech therapist. All the team members are consulted during discharge planning. As a member of the team, the occupational therapist can suggest whether further treatment or more specialized rehabilitation is required. In such a case, a team from the hospital's specialized unit is called to assess the patient for potential rehabilitation. Throughout this process, the patient is not discharged until the occupational therapist deems appropriate.

Equipment is supplied by the hospital through a Home Loans Scheme and it is given free of charge for the required time period. If a patient needs help with his

daily tasks, an application for Social Services is made. This means that a home-helper goes to the patient's home from once to four times a day as advised, to help with both self-care needs and meal preparation. If a patient requires further rehabilitation at home, a referral can be made for an Intermediate, Community or Social Services occupational therapist.

Apart from the general medical wards, occupational therapists also work at the Admittance and Emergency Department, and the Medical Assessment Unit to help identify whether a patient is to be discharged home. Other therapists work in different areas such as the Neurorehabilitation Unit, Stroke Unit, Pain Clinic, Splinting Unit, Home Loans, Intermediate, Community and Social Services. I was given the opportunity to visit these units and to spend a day or two in the different areas to observe occupational therapists working in these settings.

Apart from the hospital-based occupational therapists, other O.T. departments outside the hospital setting provide community-based services. There are occupational therapists employed with the Home Loans Section which provide equipment to patients prior to discharge as advised by the therapist. This equipment is given free of charge and for the necessary time period. The Intermediate occupational therapist visits the patient at home to assist with rehabilitation, such as retraining of activities of daily living after a stroke or a total hip replacement, whilst the Community occupational therapist visits the patient if further practice using any aids or equipment supplied by the Home Loans is required. The Social Services occupational therapist is involved when major adaptations are required such as converting an existing bathroom into a walk-in shower.

Besides having a different health care system, cultural differences also have an effect on the attitudes patients have towards life in general. They seem to have a general positive attitude, and seem to be more committed to their rehabilitation. The majority of the patients are willing to return home and continue living within their own environment with any necessary environmental modifications or social and/or community services. If a patient is unable to return home, a transfer to a nursing or residential home in the same area or the vicinity, can be arranged.

Home visits are carried out when necessary to assess the need for any immediate aids or adaptations in the patient's home in view of his discharge. Generally, the therapist is accompanied by the patient him/herself and assesses the patient using any aids within the home setting. When this is not possible, the therapist carries out the home visit in the presence of the patient's relative, or carer only.

Overall, this experience was very fruitful and enriching. The time period of six weeks which was allocated for this placement was sufficient for me to look at occupational therapy from a different point of view, and to get another perspective of its role in enabling a person to continue living as independently as possible. Working within a team setting was very inspiring since seeing all the different professionals working together to be beneficial for the patient himself. Due to the rapid patient turnover, the therapist has to be efficient and effective in assessing and treating the patient in order to help him regain his confidence and to return to his previous level of function. Working within the structured environment provided by the National Health Service (NHS), whose objective is to maintain the people, especially the elderly and people with disabilities, within their own home clearly offers the occupational therapist great job satisfaction.

First Hand Involvement in Treatment

This clinical placement in Derby gave me the opportunity to share and discuss different techniques and treatment approaches used. It even helped me to compare and contrast the different working environments and to observe the efficiency and practicality of the treatment provided. Furthermore, I was also given the opportunity to carry out initial interviews with the referred patients, prioritize treatment aims and complete the necessary assessments to guide the patient until discharge.

Communication with other team members on an individual basis, and participation in team meetings was ongoing. When necessary, liaison with the patient's relatives, social services or care managers was carried out to determine further care at home. I also attended various home visits to determine any structural/environmental changes and aids the patient might need, and to identify any hazards which might lead to further falls

or injury to the patient. Throughout the whole placement, I was supervised by a therapist who offered me her support and advised me accordingly.

Keeping a patient's file up to date and noting down difficulties a patients may encounter and which could hinder living independently and safely at home, is of the utmost importance, as it indicates which community services need to be provided. This ensures that staff are safeguarded in case of litigation. Data protection is also given a lot of importance in the UK and patient confidentiality is paramount.

Occupational Therapy Skills

From this experience I can confidently say that Maltese occupational therapists are well equipped with the practical skills to cope with different hospital and treatment set-ups. I observed that the occupational therapists in the UK have very specific areas of intervention. For example, basic grade therapists are not required to assess and identify physical (particularly range of motion, hand function, tone), sensory, cognitive and perceptual problems of a patient who had been admitted with a mild stroke. The focus of their treatment is entirely different. The main aim of these wards is to discharge the patients to their home as soon as possible. Therefore the focus of occupational therapy services is assessment and the provision of equipment which would be necessary for the patient to be able to cope at home independently and safely.

Rehabilitation similar to what we are used to finding in our clinics is practiced in the specialized units or by the Intermediate occupational therapists in the community. At times, this proved to be frustrating for me, as in Malta, we are trained to assess in depth all the main problem areas and to devise a rehabilitation programme to address the specific performance components. Compensatory techniques are taught to the patient when his/her potential is reached or in view of discharge home. Practical and possible solutions are explored to enhance and maintain independence and promote safety, in spite of the limited social services available. As a 'Home-Loans' service is not available in Malta, the equipment recommended generally has to be bought by the patients or relatives. As finances are usually a problem for the people who rely on a disability or old-age pensions, the occupational therapists in Malta are faced with further challenges to

be practical and creative in recommending equipment which would be useful and safe for the patient with a low budget.

Lessons Learnt

On my return to Malta, I was determined to try and pursue some of the ideas inspired by the placement at Derby City General Hospital. These included the use of particular O.T. assessments and protocols. To implement other ideas would require a change in the occupational therapy perspective and also a concerted effort by all the other different health professions. Working as an interdisciplinary team to achieve the patient's maximal potential, still has to be addressed properly at St. Luke's Hospital which is presently run predominantly on a medical model. It is imperative that during the rehabilitation process, a more holistic view of the patient is taken. In turn, this may reduce the probability of the patient being readmitted into hospital. Other matters would need to be dealt with by a more efficient and effective local health care system. Creating a social services system similar to what has been existing in the UK for quite a number of years, is one example but this requires a radical change in health care service delivery on Malta. Community care services, including occupational therapy, would reduce the number of admissions to hospital, therefore, reducing the ever-increasing number of social cases at St. Luke's Hospital. Having a system within the health department for loaning a wider range of rehabilitation aids and equipment will make the recommendations made by the occupational therapist feasible thus enabling patients to remain independent and safe in their own home.

I strongly encourage other occupational therapists to take such an opportunity to experience first hand how other professionals work abroad in a different set-up. This would certainly help to motivate and inspire them with new ideas as well as affirm their role within their workplace. This placement was a unique experience for me and I would like to thank the people involved in making it possible.

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