Realising Rehabilitative Palliative Care

Capturing now and looking to the future

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Doctors will also want to work more closely with geriatric and Rehabilitation medicine, cardiology and respiratory medicine and with general practitioners in recognition of the changing profile of people seeking palliative care.
Rehabilitative Palliative Care can be defined as follows:

Rehabilitative Palliative Care is a paradigm which integrates rehabilitation, enablement, self-management and self-care into the holistic model of palliative care. It is an interdisciplinary approach in which all members of the team, including nurses, doctors, psychosocial practitioners and allied health professionals, work collaboratively with the patient, their relatives and carers to support them to achieve their personal goals and priorities.

Rehabilitative Palliative Care aims to optimise people's function and wellbeing and to enable them to live as independently and fully as possible, with choice and autonomy, within the limitations of advancing illness.

It is an approach that empowers people to adapt to their new state of being with dignity and provides an active support system to help them anticipate and cope constructively with losses resulting from deteriorating health.

Rehabilitative Palliative Care supports people to live life fully until they die.
Rehabilitation

- Aim to maximise quality of life for patients and families
- Multidisciplinary Approach
- Involve patient and family in care planning
- Optimise physical function and emotional wellbeing to highest extent possible
- Consistent with patient goals, priorities, and limitations
- Holistic

Palliative Care
WHAT
is Rehabilitative Palliative Care?

WHY
bother with Rehabilitative Palliative Care?
Patients Priorities and Preferences

Significant body of evidence show patients’ priorities focus on *Life and Living*

- Maintaining continuity of daily life
- Living a normal life for as long as possible
- Maintaining physical function and independence: ‘the ability to care for oneself and do what one wants


Evidence of Efficacy

Growing body of robust evidence supports a rehabilitative approach as both *acceptable* and *effective* for people receiving palliative care

Economic Value

Functional disability and caregiver dependence crucial contributors to cost in last year of life
WHAT is Rehabilitative Palliative Care?

WHY bother with Rehabilitative Palliative Care?

HOW to realise Rehabilitative Palliative Care in practice?

How rehabilitative is your hospice? A benchmark for best practice
All members of the multidisciplinary palliative care team integrate principles in their daily practice and support of patients

- All members of the multidisciplinary team actively give patients the opportunity to do things for themselves before offering assistance.

- Where support is needed with physical activities, verbal prompts or tips for activity independently are offered before providing hands-on assistance.

- Where hands-on physical tasks are agreed in advance by the patient and provided with their consent, whenever possible.

NB: Even patients who are in the last days of life can be supported through an approach to care – this may simply involve supporting them to wash their genitals if they are able to, or choosing which position is most comfortable.

- Nursing staff and assistants utilise motivational interviewing approaches to participate in ADLs when they have capacity. For example, if a patient is out of bed, the staff member explores the reasons why and identifies any factors to address.
Rehabilitative Palliative Care

Current Reality
Where are we now?
What is the challenge we are facing?

In one word:

Future Vision
Where would we like to be?
What does this look like? When? (SMART)

Success!
What is your best success?
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STRATEGY

'many attempts at changing organisational cultures are 'strong on prescription but lamentably weak on diagnosis''

Brooks and Bates 1992
Culture
‘The glue that holds an organisation together through shared patterns of meaning. Culture focuses on the values, beliefs and expectations that members come to share.’
Siehl and Martin 1984

‘Cognitive maps’
The values and way of thinking from which one assesses patients and delivers care.

Subculture ‘Occupational Communities’
‘a group of people who consider themselves to be engaged in the same sort of work, whose identity is drawn from their work; who share with one another a set of values, norms, and perspectives that apply but extend beyond work related matters…’
Van Maanen and Barley 1984

New recruits are socialised through the modelling of distinctive ways of thinking and behaving that characterise each discipline  Hall 2005

Incorporating the profession’s value system into the individual’s world view is a subtle process and unfolds largely unspoken  Roberts 1989
Leaves and Foliage: Palliative Care Practice

Branches:
- Represents different professional practices within the team – tasks performed by the team in delivering patient care
- Together they support each other and allow the team to function
- If the branches do not work in harmony the tree’s canopy will not be supported

Trunk:
- Represents collective identity of the MDT
- Binding common ground through shared values of Palliative Care and Intuitive Practice
- Supports the palliative care team
- Enables and sustains growth

Roots:
- Underlying philosophy and value systems of individual professions within the team
- Hidden but ‘feed’ the trunk
- May be assumed, ignored or unexplored
1 Identify underlying philosophy, values and principles that drive profession and way of thinking
   - Be reflective and examine own professional identity
   - What is your ‘Cognitive Map’?
   - Identify strengths and opportunities for MDT

‘Cognitive maps’
The values and way of thinking from which one assesses patients and delivers care.

‘quite literally, two opposing ‘disciplinarians’ can look at the same thing and not see the same thing’
Petrie 1976
Rehabilitative Palliative Care

STRATEGISING

Building mutual trust
Co-creating a shared way of thinking or a new ‘cognitive map’

REALISING

• Conscious relationship building
• Informal coffee vs formal meeting
• Joint working vs formal teaching
Culture Change

Who are the key groups or stakeholders I/we need to have on board to achieve our goal?
Do I/we know where are they coming from?
What are the values and philosophies of their ‘Occupational Communities’?
How might these inform how we could work together towards a shared goal?
### Action Plan

What steps do I/we need to take? Which are the priorities? By when?

1. 
2. 
3. 

### Future Vision

Where would we like to be? What does this look like? When? (SMART Goal)

### Current Reality

Where are we now? What is the challenge we are facing?

### Success!

What is your best success? How are you celebrating and sharing this?