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Risky Business

The Value of Adding Dignity of Risk in Rehab

SMALL STEPS. GIANT STRIDES.

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Defining Dignity of Risk

And how it applies in our setting

Ashley Jackson, DON

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Our Unique Population

- Brain injury/Neuro rehabilitation
  - Stroke, TBI, ABI, SCI, Guillain-Barre, other.
- Average length of stay 58 days
  - Quick turnaround for admissions and discharges, discharge plan is often home
- Impulsive/cognitive challenges
  - Impulsivity and decreased safety awareness is common
- Physical challenges
  - Affected extremities, contractures, dexterity, pain
- Acuity of our population
  - 60% higher than the state Medicaid acuity average
- Therapy- 3 to 5 hours of core therapy a day
- Age 10 and up- average is 40-50 years old

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Why is dignity of risk important?

- Short length of stay- 75-80% discharge home
- Our goal is to prepare our person served for real life circumstances- this means we need to give them opportunities to be as independent as possible.
- For person served to improve from a mobility standpoint, we need to push their ability in the nursing unit as well, therapy takes up about 3-5 hours each day.
- Physical freedom to learn and have ability to make errors.
- Dignity team
  - Assesses behaviors and assists in determination of risk vs benefit for safety measures

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Medical Model vs Rehab Model

Medical Model	Rehab Model
Driven by safety, can often be restrictive	Driven by function and independence
Bound by regulatory requirements	Freedom for errors
Prevention or cure focused	Adaptation and solution focused
Patient is a passive participant in treatment	Patient is an active participant in treatment
Fixing the condition	Living with the condition

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Finding the Balance

Collaboration between therapy and nursing is key to determine the true risk for each person

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Interventions and Examples

We know falls are going to happen, but we still want to prevent them when we can and give our person served the tools to be successful.

Physiological Needs • Toileting schedule • Frequent checks • Assistive devices nearby	Impulsivity • Red sock • Location • Alarms or monitors	Perseveration • Visual cues • Redirection techniques • Activities
• Memory • Signage in room • Stop net by door • Red sock	Attention • Frequent checks • Labeling call light/devices • Signage in room	Environmental • Call light • Room set up • Equipment set up

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Interventions

- Red sock over seatbelt
- Stop sign/visual cues in room

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Other Interventions cont'd

Video monitoring systems

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Other Interventions Cont'd

- Adaptive call lights
- Call light ambassadors



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Involving Staff in the Process

Rehab 16 Rounds

- Collaborative rounding between nursing and therapy team members to discuss how person served are doing on the nursing unit.
- Rounds occur on Mondays and follow up on Thursdays.
- Involving staff in both the discussion and decision-making process helps with buy in and cohesiveness across the departments.
- The team continues to evaluate and discuss safety with dignity of risk weekly.

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Get Up and Get Moving

Functional Mobility
Taylor Albaugh PT DPT

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You Will Never.....

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Words Matter

- Red Flags: not allow, get in trouble, told me no, can't, broke the rules, getting caught, let them
- This is not "our" rehab, it's "their" rehab
- This really applies to the people who are pushing us outside of our comfort zone and how we respond to them pushing the "limits"
  - With other people, you may have to be the one to push them past their comfort zone

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Why is it important?

- Builds confidence
- Gives control back and a sense of self
- Builds chips (rapport), establishes trust
- Inspires hope for now and the future
- High repetition practice
- Variable scenarios
- Better discharge planning

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How do we decide the limit and mitigate risk
It depends.....

- Age
- Body composition
- Bone flap/helmet compliance
- Orthopedic conditions, Weight bearing status
- Cervical collars, TLSO, braces
- Blood pressure concerns, upright tolerance
- Hemiplegia/neglect
- Seizures
- Blood thinners
- Vision
- Agitation levels
- Lines/cords/tubes
- History of falls
- Discharge plan
- Caregiver abilities
- Mental health
- Communication

....the list goes on.....

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What do we do?

- Berg Balance Test
- Dynamic Gait Index
- Safety Kitchen
- Transfer Trackers
- Simulated schedule practice
- Communication Access
- Public space practice
- Different times of the day (AM vs PM)
- Practice

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MacGyver

- "Non-traditional" set up or strategies
- Get creative
- Give it a try

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Bathroom/Room: Transfer into bed, get to the bathroom

- Transfer trackers
- rearrange room to transfer to strong side
- parking space on ground
- visual list of w/c set up
- different transfer style (slideboard vs stand pivot)
- assistive device use (cane vs no device)
- time of day (during the day when awake, call for assistance at night)
- bedside commode
- change rooms
- night lights
- wear grippy socks when in bed
- commode over toilet for added support
- transfer to toilet then call for help with clothing/hygiene
- motion sensor instructions ("do you have your helmet on)
- from a wheelchair level vs walking
- door stop

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Wheelchair propulsion

- Manual chair, Powerchair
- Difficulties: obstacles, wheelchair set up, speed, left neglect, pathfinding
  - keep clear paths in hallways and in rooms
  - adding bright colors to wheelchair parts
  - visual lists for wheelchair set up
  - signs around building for path finding
  - adjusting powerchair speed limits and sensitivity
  - switching powerchairs into manual mode in rooms
  - using arm rests to protect hemiplegic limbs
  - foot straps to keep hemiplegic legs on foot pedals, wander guards
  - 15-minute checks

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Outdoor Independence

- Each discipline check off
  - PT/OT physical mobility outside
  - SP communication for going outside/coming back inside or alerting if something is needed
  - Clinical counselor – elopement concerns or other outdoor "temptations"

- Cellphones, doorbells, walkie talkie
- Enclosed spaces, flat terrain, parking spots
- 15-minute checks
- Buddy system
- Powerchair vs manual chair

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Family Training

- Get training started early and often
- Consider caregiver limitations and adapt
- The more repetitions and practice that can be done in a controlled environment with help around, the better prepared for home/community
- Encourage family participation with everything
- Let family use equipment

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Using exercise equipment outside of therapy time -

- Clearing to use the "LAB" and other equipment outside of traditional therapy time
- Demonstrates ability to use equipment safely
- Information placed in "orders"
- Family/friends can assist if needed
- Use of communication where someone is going
- 15-minute checks
- Gives a person some ownership to what they can and want to do
- Added value to their day/afternoons/weekends

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Everyone plays a role

- Non-traditional tasks – everyone working to common goal
  - Walking with SLP
  - RT transfers
  - CNA training
  - Family/friends
- Everyone jumps in
  - Kitchen, facility, HR, other families

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Treatment sessions – Risk it for the Biscuit

- "Falling" isn't the end of the world
  - Controlled lower to the ground
- Making mistakes are a good thing
- Errors = learning
- If it's easy, we don't need to practice it
- What if it goes wrong... but what if it goes right?

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1. 50 year old male, L CVA and starts self-transferring...eventually leading to walking around facility.
2. 60 year old female, TBI, agitation, confusion, aphasia and needs to be on the move.
3. 35 year old male, L CVA with significant mobility impairments, limited verbal communication, high pain levels and a low frustration tolerance.
4. 60 year old male, R CVA, used powerchair and was always cold.
5. 28 year old male, TBI, very ataxic but always seemed to catch himself and wanted to be doing more.
6. 45 year old male, R CVA, weighed > 400lbs and hadn't been out of bed since injury.

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Cognition, Communication, and Swallowing

Alison Whitaker, SLP

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Examples of Potential Risks

- Cognition/Communication:
  - Falls and injuries
  - Getting lost
  - Not completing ADLs
  - Errors with managing chronic or acute health conditions
- Swallowing:
  - Choking
  - Aspiration pneumonia
  - Malnutrition/Dehydration
- Our job is not to ignore these risks but to educate on them and partner with Persons Served and their care partners to support them in decisions they make regarding risk

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Person-Centered Care and "Acceptable" Risk

- Collaborate with Persons Served and family to understand what is an acceptable level of risk for them.
- Considerations:
  - People differ in their own goals
  - People differ in their risk tolerance
  - People differ in their cognitive, communication, and medical presentation

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"Acceptable" Risk – Individual goals

- When you ask Persons Served what their main rehab goals are, what do most people say?

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Individual Goals

- Walking? Home? Independence with personal cares?
- Ways to support these goals while mitigating risk:
  - **Cognitive** supports for memory, sequencing, or problem-solving
    - External and environmental supports such as **signs in room**, **tape on floor**, **written sequence** of transfer steps, **removing obstacles**, **placing wheelchairs/walkers/beds strategically**
    - Caregiver **education**
  - **Communication** supports for requesting assistance
    - Practicing with **call light usage**, problem-solving communication needs at discharge (e.g. **fall-alert watches**, **life alert**, **independent phone use**, **smart home options**)
  - **Swallowing supports** to reduce choking or aspiration risk
    - **Supervision**, **strategy usage**, **adaptive equipment** (e.g. **Provale mug**, **nosey cup**, **smaller spoon**, **mirror**), **set-up assistance** (e.g. **cutting food** into appropriate size), good **oral cares**, **practicing tooth-brushing**, **training on Heimlich** presenting preferred foods in a **different way**

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More ways to support swallowing goals

- If Persons Served choose to eat or drink things they are known to aspirate, can we mitigate the risk in other ways?
  - Presenting the food in a different form
  - Offering a small amount of the food (tastes)
  - Training specific staff or care partners
  - Free water protocol
  - Improved oral health
  - Improving general health

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"Acceptable" Risk – Individual Risk Tolerance

- Our Persons Served come to use with widely different tolerance of risk in their own lives.
- Some people may be more inclined to prioritize health and safety than others.

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Differing Presentations Lead to Differing Approaches

- Examples of cognitive differences:
  - Significant confusion or anosognosia leads to the need for more support from caregivers and health professionals in determining acceptable risk
- Examples of communication differences:
  - Significant aphasia can make it challenging to provide education on risk and recommendations, leading to "riskier" behavior from these Persons Served

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Differing Presentations Lead to Differing Approaches

- Examples of medical differences:
  - Missing bone flap or osteoporosis (falls are a bigger deal)
  - Respiratory compromise (aspiration is a bigger deal)

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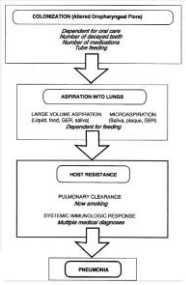
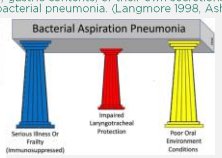
Understanding & Mitigating Pneumonia Risks

Bacterial aspiration pneumonia can occur when immunosuppressed people with poor oral health aspirate either food, liquid, gastric contents, or their own secretions into the lungs. Dysphagia alone doesn't cause bacterial pneumonia. (Langmore 1998, Ashford 2024)





"These three factors, or pillars, must be present simultaneously for BAP to develop (18–20). Reducing or eliminating the effects of any one of these three factors through focused treatment significantly reduces the likelihood of BAP developing." (Ashford 2024)

"Those receiving sponge oral hygiene care had a 3.94 times higher rate of pneumonia than those using toothbrush cleanings." (Ashford 2024)

Fig. 1. Significant predictors of aspiration pneumonia (in bold italics) positioned in the model.

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Brief Case Study: A.K.

- Mid 40's, married father of three. Significant cardiac history. Multiple bilateral strokes. Significant oral and limb weakness. Difficulty with chewing food and moving it back.
- Was on **puree diet and thin liquids**. Dependent feeding due to limb weakness. Difficulty with getting purees down due to oral weakness and incoordination. Meals taking ~1 hour.
- Went to the farmers' market with his wife one day.....


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Maintaining Dignity During Discharge

Stephanie Schmid, OTR/L

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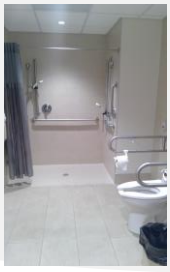
Home...Removing the Safety Net



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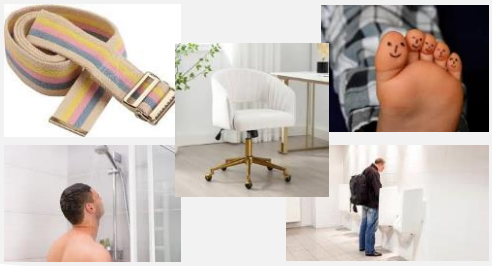
Getting Comfortable in Risky Reality



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Preparing for Discharge with Dignity

- Adults with a right to choose a discharge plan that has a greater level of risk than our comfort level
  - Our job is to help them put as much thought, preparation and planning for home before they get there
- Home evals
- Community outings
- Day passes
- Family transporting to appointments
- Overnight passes
  - Setting up days for loved one to be lead in providing care
- Structure- Strategies for planning out day/week to include productive time before leaving OWL

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Case Studies

- 68 y/o Gentleman, TBI, Rancho 4, visual impairments. Plan discharge with his wife with 24/7 supervision to split level home
  - At OWL had enclosed bed, tilt in space wheelchair, pen release seatbelt
- 62 y/o Gentleman, Right CVA, hemiparesis. Discharge plan home independently to accessible senior living apartment. His closest family lived 45 minutes away.
- 34 y/o Gentleman, Left CVA, visual impairments, hemiparesis. Plan to discharge to local long term stay hotel temporarily for outpatient.

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Dignity of Risk in Return to Life & Community

Sydney Boustead (Woodruff), CTRS

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Common Risks to Consider

- Walking/ambulating WC on uneven terrain
- Van transfers
- Navigating large crowds & uncontrolled environments
- Swallowing
- Overstimulating environments
- Time/money management

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Common Goals to Consider

1. Regain sense of normalcy
2. Test ability to return to an activity
3. Trial activity modifications
4. Practice rehab skills in an uncontrolled setting
5. Life enrichment

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Behind the Scenes of an Outing:
What We Consider to Make a Risk Reasonable

- Vans
  - Transfer or WC
- What staff need to go?
- Staff Ratios
- Necessary Supplies
  - Thickening packets
  - Whiteboards
- Prechecking Menus
- Parking
- Family
- Bathrooms
  - Supplies
  - ID Locations
- Time of Day
- Length of Outing
- Outing environment
- Educate community staff
- Assistive devices

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Farm Outing: Crop Scouting

The opportunity to...

- Trial return to farming
- Incorporate their passions into their therapy
- Practice rehab skills in a purposeful environment

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State Fair Outing

The opportunity to...

- Feel part of the community
- Participate in personal traditions
- Practice identifying accessible routes and features

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Target Outing

The opportunity to...

- Provide gifts to their loved ones
- Complete Holiday traditions
- Practice money & time management

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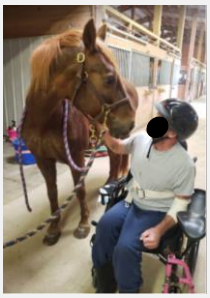
Equestrian Outing

The opportunity to...

- Be in their "happy place"
- Experience an improved mood
- Use leisure as a mode to practice therapy skills



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Paintball Outing

The opportunity to...

- To trial adaptive gameplay
- Freedom of choice
- To experience joy in leisure post-injury

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Accessible Outing Locations in DSM

- Easter Lake
- ActionTrak Chair at Big Creek
- DSM Skate Park
- Blank Park Zoo
- Botanical Garden
- Science Center
- Farmer's Market

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