

Koforidua St. Joseph's Orthopaedic Hospital, Ghana Physiotherapy report

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St. Joseph's has four male wards with side rooms, four female wards with side rooms, three paediatric wards and a private ward made up of double rooms (approx 140 beds). They have a physiotherapy department which runs outpatients in the mornings and inpatient physiotherapy in the afternoons. This is staffed by three full time members of staff. This report is based on the CSP's Core Standards of Physiotherapy Practice 2005.

Staffing

The hospital has a senior physiotherapist from India and a senior nurse who has done 6 months training in physiotherapy in Spain who had good knowledge and skills baseline. There is a physiotherapy assistant who at the time of our visit had had four months training under the physiotherapy team. The senior nurse who has done some physiotherapy training appeared to have the greatest depth of knowledge and skills. She has a good grasp of what the patients need to achieve for discharge planning and progression.

Patient Partnerships

Standard 1: *Respect for the patient as an individual is central to all aspects of the physiotherapeutic relationship and is demonstrated at all times.*

The physiotherapy team demonstrated awareness of patients economic, social, occupational and psychological impact of their injuries. There was a language barrier between the senior physiotherapist and patients, however the team overcame this well through joint sessions.

There was no evidence of an introduction to patients of what physiotherapy is or the role of the physiotherapy sessions. Nor did the team inform the patient of if they were being treated by a qualified member or unqualified. Inpatient privacy is an issue, within the wards there are screens, however, only the nursing staff use these. Outpatient physiotherapy has a good layout, with a gym and individual side walled cubicles.

Recommendation:

- 1) Improve patient awareness of the role of physiotherapy
- 2) Improve patient/professional introductions in order to gain informed consent for assessment and treatment
- 3) Give the patient the option of privacy during the physiotherapy sessions.

Standard 2: *Patients are given relevant information about the proposed physiotherapy procedure, taking into account their age, emotional state and cognitive ability, to allow valid consent to be given.*

There was some evidence of verbal patient consent to assessments and treatments. However, there was not always an explanation of treatment plans or treatment goals with the patients. Patients were not always given the opportunity to ask questions. Some patients declined physiotherapy; one common reason given was that they could not afford it.

Recommendation:

- 1) Patients need to have assessment and treatment sessions explained and the patient and physiotherapist should plan their treatment together.
- 2) Improve communication, E.g. it's always nice to ask the patient if they have any questions
- 3) A basis level of physiotherapy should be worked into the hospital stay fees, as this would reduce length of stay, clear bed blockers and improve patient recovery and functional ability greatly.

Standard 3: *Information which the patient gives to the physiotherapist is treated in strict confidence.*

There were no identifiable problems with verbal confidentiality and the patient register and patient cards were kept in the physiotherapy department which was locked at the end of the day.

Assessment and treatment cycle

Standard 4: *Information relating to treatment options is identified, based on the best available evidence, in order to deliver effective care.*

The physiotherapists has lists of patients who needed to be seen, however, when questioned they were uncertain of how the patients had been treated or if the fixation had been done well or not. This was made difficult as check x-rays were not standard as the patients had to pay for them. Nor were they sure of patients weight bearing status, hence the majority of the patients were left in bed and given the same exercises. There was some evidence of clinical reasoning when talking about the patients present complain and reviewing x-rays, however, there was limited evidence of tailored treatment plans and slow progression of treatment plans, which delays discharges. Previously, patients operation notes would not include post operation instructions, thus making it difficult to rehabilitate patients.

There was no evidence of evidence based practice, clinical guidelines, local standards or protocols. No sign of outcome measures or written reflective practice sheets being used. *However, this is directly linked to limited funding*, information resource and difficulty accessing the internet and awareness of how to access the relevant research.

Recommendations:

- 1) Teaching sessions on evidence based practice, outcome measures, clinical reasoning and development of hospital protocols.
- 2) Funding for a resource library and access to the internet for research purposes
- 3) Education on reading x-rays, common surgical interventions and the differences relating to rehabilitation.
- 4) Improve communication between the physiotherapy and medical team re: post op instructions.

Standard 5: *Information relating to the patient and his/her presenting problem is collected.*

There is limited evidence of patient notes and limited assessment skills, E.g. muscle strength, ROM, observation of contractures. During the visit, a form had been developed to record the patients detailed history. However, up to then there was not evidence of physiotherapy records for inpatients except a billing record. Outpatients have a patient register which they write a summary of the treatment. The physiotherapy team did not know what the patients diagnoses were, how or if they were fixed or their WB status. I feel this is a direct result of not having any documentation.

Recommendations:

- 1) Full individual records are required for both in and outpatients, which should have detailed entries of each patient contact.
- 2) Education on documentation and the legal responsibilities.
- 3) There should be a separate inpatient and outpatient record book to record the patients, PC, their management, PMH, SH, WB status, and a tick box for the days seen.

Standard 6: *Taking account of the patient's problems, a published, standardised, valid, reliable and responsive outcome measure is used to evaluate the change in the patient's health status.*

There was no evidence of any outcome measures or even access to outcome measures. The team were unclear of what outcome measures were and there use.

Recommendations:

- 1) Education on what outcome measures are, how and when they should be used.
- 2) Provide the basic standard outcomes measures for them and train them how to use them.
- 3) Provide with Internet access to allow them to access professional bodies and specific outcome measures.

Standard 7: *Analysis is undertaken in order to formulate a treatment plan, following information gathering assessment.*

There was limited outpatient documentation, however, not detailed. There was no evidence of written clinical reasoning, problem lists, treatment plans or treatment goals for in or outpatients. There was some evidence of the physiotherapist's diagnosis the outpatients with musculoskeletal conditions, but limited evidence of their clinical reasoning which concluded their diagnosis.

Recommendations:

- 1) Proper documentation needs to be put in place
- 2) Education about normal and abnormal anatomy and biomechanic, subjective and objective assessment, musculoskeletal conditions, special tests, clinical reasoning and treatment options.
- 3) Training on subjective and objective assessments.

Standard 8: *A treatment plan is formulated in partnership with the patient.*

There was no evidence of goals, risk assessment or time scales for implementation of treatment ideas. Part of this may be due to inadequate physiotherapy staff. The team appear to work quite separately from the nursing staff. The nursing staff does not have any input in assisting patients to mobilise or sit out in the wooden chairs. However, through education the nursing staff has begun to get involved in this.

There was some evidence of patient involvement with treatments however on the whole the patients were given exercises to do without patient involvement in planning their treatment. This could have been due to time constraints, too large a caseload, and maybe communication problems as some significant number of did not speak English and the team could not speak some of the languages of the patients.

Recommendations:

- 1) Improve knowledge and skill baseline within all aspects of physiotherapy, both clinical and non-clinical through education.
- 2) Improve nursing staff's knowledge of the importance of early mobilisation, basic bed exercises and their role in encouraging the patients to do them, education on how to mobilise patients and the difference reasons for WB statuses. (Already started and in practice from Jan-Feb 07 trip)

Standard 9: *The treatment plan is delivered in a way that benefits the patient.*

No evidence of treatment plans.

No evidence of information or advice sheets for patients, due to funding.

No equipment is loaned, due to the lack of equipment and funding

Recommendation: Correct documentation and Fund raising

Standard 10: *The treatment plan is constantly evaluated to ensure that it is effective and relevant to the patients changing circumstance and health status.*

No evidence of treatment plans, subjective or objective markers.

Standard 11: *On completion of treatment plan, arrangements are made for the transfer of care/discharge.*

At present when a patient is ready for discharge they are advised to purchase their own walking aids if required, once they have these and they have paid their bill they are discharged home. However, if they are not able to pay their bill they will stay at the hospital until it is paid. This has a large impact on bed blocking.

There is outpatient physiotherapy which anyone can attend as long as they pay, however, there is no community physiotherapy service, occupational therapy service, social services or intermediate care centres which I understand is a typical scenario across Ghana. Residential homes or Nursing homes, I am told are not common in Ghana. Patients are therefore discharged home. Patients have to be functionally close to their baseline before discharge if they cannot afford to come to the outpatient department.

Recommendation:

- 1) Maintain a high level of communication and treatment planning between the physiotherapy team and the patient.

Communication

Standard 12: *Physiotherapist communicates effectively with patients and/or their carers/relatives.*

The physiotherapy team demonstrated good communication on the whole with some of the patients.

Recommendations:

- 1) The subjective and objective assessments need to be more detailed and documented in order to plan treatment and discharge.
- 2) Ongoing communication with the patient and family to advise on how to continue with their rehab at home.

Standard 13: *Physiotherapists communicate effectively with other health professionals and relevant outside agencies to provide an effective and efficient service to the patient.*

There was evidence of communication between the physiotherapists and the doctors and nurses regarding patient's medical state and referral to physiotherapy. However, it was not always clear whether the physiotherapist's feedback to the nurses on the patients progress, abilities to mobilise or any discharge plans. This was also emphasised with the lack of any documentation in the patients medical records.

Recommendations:

- 1) Physiotherapy documentation
- 2) Organised MDM's (Multidisciplinary meetings) once a week.
- 3) Comply to the criteria under standard 13

Documentation

Standard 14: *To facilitate patient management and satisfy legal requirements, every patient who receives physiotherapy must have a record.*

There was some evidence of individual patient records for outpatients and inpatients in the form of an appointment card, which recorded the patients name, approximate age date of initial appointment and how many sessions they received. However, this was very limited and did not include any specific medical details about them or their reason for admission. Nor did it include details of their physiotherapy sessions.

At the end of the Jan/Feb 07 trip they had in place a front sheet which they would be able to document the patients demographic details, PC, HPC, PMH, SH and DH. On the reverse of this sheet they were going to document their on going physiotherapy sessions. However, a barrier to this is their large caseload, time constraints and lack of knowledge of SOAP or formatted notes.

Recommendation:

- 1) Education on how to document correctly
- 2) Education to nursing staff of which patients to refer to physiotherapy and improved nursing support and team work to help reduce caseloads and time constraints.
- 3) Notes audit once up and going

Standard 15: *Patient records are retained in accordance with existing policies and current legislation.*

The patient records which the physiotherapy department have are kept in a cupboard in a lockable room at the end of the day. It wasn't clear whether there were any local health informatics security policies, nor was it clear what happens to the documentation once treatment has ended.

Recommendation:

- 1) Local health informatics security policies need to be identified by motec and local physiotherapy team.
- 2) If there are none then the hospital could comply with the criteria in standard 15 of the CSP Core Standards.

Promoting a safe working/treatment environment

Standard 16: *Patients are treated in an environment that is safe for patients, physiotherapists and carers.*

The physiotherapy department is a good size, well put to use. It has a reception area following on into the gym, then opens up on the right to 4 or 5 outpatient cubicles with partition walls and curtain fronts. There are also two toilets. The gym has ceiling fans to help with the hot weather.

Infection control is one of the largest areas for development. There are cotton sheets on the plinths, however, these are not changed between patients, it is unclear how or when these are cleaned. There is evidence of gloves and a limited supply of alcohol gel, however, the gel is not used. Gloves are seldom worn and when worn they are not changed between patients. There is a sink in the physiotherapy department however, the physiotherapy staff do not wash their hands after each patient, only at the end of the clinic.

There three sisters offices with a sinks in for the female, male and paediatric wards, each ward contains twelve beds and the furthest ward aware from the office is approximately 70m away. There are no toilets for the patients therefore they use commodes or buckets. There appears to be no washing facilities for the patients to wash themselves. There are gloves available and evidence of a limited supple of alcohol gel, however, these were not observed being used except for nursing duties. There was no evidence of hospital cleaners and the ward cleanliness was poor. Family relatives slept in between the beds on the floor at night. There were no waste or clinical waste bins on any of the wards to dispose of used gloves. Consequently, staff would go from patient to patient without washing their hands, wearing gloves or using alcohol gel and thus infection risks was high. The bed sheets did not get changed regularly, thus increasing the risk of infection. This is against the background of poverty, lack of funds which consequently affects staff morals.

Recommendations:

- 1) Education about infection control, how to combat cross infection
- 2) Increase the provision of gloves, alcohol gel, plastic aprons and waste bins
- 3) Hand washing facilities need to be put into each ward
- 4) Toileting and washing facilities are also require for patient use
- 5) Education and implementation of risk assessment

Standard 17: *Physiotherapists take measures to ensure that the risks of working alone are minimised.*

This is not relevant because there is no provision for community work and therefore no lone working.

Standard 18: *All equipment is safe, fit for purpose and ensures patient, carer and physiotherapist safety.*

The physiotherapy department holds parallel bars, wall bars, upper limb exercise equipment, wooden stairs, three or four bikes, although in a poor state, a tilt table, lower limb weight machine, free weights and a gym ball. Also there is a heated massage bed; heat lamps; PSWD machine; Ultra sound machine and a freezer providing ice packs. However, the electrotherapy machines are not working and none of the equipment has yearly checks.

There are limited walking aids on the wards however, all of these are unsafe and needed cleaning on regular basis. Patients are encouraged to buy heir own walking aids as these are not provided for discharge. They are able to purchase rollator frames, auxiliary and elbow crutches. There was no evidence of any manual handling equipment available. Fortunately the patients have a high pain threshold and on the whole are very strong and resilient. The beds on the ward are very tall and did not adjust which meant that less able patients had to struggle to get on and of the beds increase manual handling risks. Patients had a chair to themselves; however, these were low wooden chairs without arms. These are not idea for patients who have had hip surgery or for skin integrity.

Recommendations:

- 1) Funding for regular equipment checks
- 2) Scheduled equipment/laundry cleaning /delegation of duties
- 3) Funding to replace condemned equipment
- 4) Correct manual handling training

Continued Professional development (CDP)

Standard 19: *The physiotherapist assesses his/her learning needs*

Standard 20: *The physiotherapist plans their Continued Professional Development (CPD).*

Standard 21: *The CPD plan is implemented.*

Standard 22: *The physiotherapist evaluated the benefits of their CPD.*

No evidence of CDP or understanding about CDP.
No evidence of clinical or non-clinical supervision

Recommendation:

- 1) Education about CPD
- 2) Introduce and develop CPD
- 3) Follow the CSP Core Standards on CPD
- 4) Implement clinical and non-clinical supervision

Report Conclusion

The physiotherapy department at St. Joseph's is a well-equipped department, well designed to cope with its patients. However, some key areas for improvement are infection control, documentation, evidenced based practice and there needs to be some continued professional development put into place. The physiotherapy teamwork well together as a team, they are all keen to learn and progress their skills. The workload for the physiotherapy team is too great for the staff however they manage well. But in order to implement the required changes more staff or a shuffle around in service provision needs to be thought about. Although St. Joseph's is mainly an orthopaedic hospital, a large number of stroke and neurological patients attend the outpatient physiotherapy department. As a result further education and training in neurology and rehabilitation would be beneficial.

President's Remarks

The report will form the basis for discussion by Motec membership and also between motec and the Authorities at St Joseph's Hospital. Motec is fully aware of the difficult circumstances that patients and staff go through. The co-operation between the staff both physiotherapy and nursing on one hand and our Motec team/ physio-therapist was an excellent example of a global resolve to achieve optimum health care for all. Obviously funding, education, and skills are the key ingredients that are chronically in short supply. Motec is at Koforidua because we did not expect it to be cosy. Motec prefers to be with Koforidua in these difficult times to help educate, transfer skills, up-grade care, working closely with all facets of the hospital. Where feasible, Motec will advise the hospital authorities to respond to patient and staff needs and help supplement the efforts from benevolent local individuals, companies and our partners abroad.