

Recovery coaching in an acute older people rehabilitation ward

Sharon Kibble, Debra Gray, Merce Prat-Sala, Kirsty Ross, Karen Johnson, Jane Packer, Elizabeth Shire, Rhian Cross, Beverley Harden
Hampshire Hospitals NHS Foundation Trust, UK

Abstract

Our patient, carer, and staff feedback clearly tells us that elderly patients are frequently disempowered by acute care provision, environments, and attitudes. This debilitates individuals mentally and physically, reducing their independent functioning, and may mean that they require prolonged care or are unfit to return home.

We developed the concept of "recovery coaching" to support acute inpatient elderly care rehabilitation. We designed a training intervention to achieve "coaching conversations" between our staff and our patients.

Data were collected from 46 participants; 22 in the pre-intervention stage and 24 in the post-intervention stage. For the post-intervention patients, mean scores indicated that there was slightly higher increase in the patient's independence in terms of their Barthel (ADL) scores and that they reported higher feelings of self-efficacy. For this patient group it was also found that more returned home with the same level of care as on their admission, and that fewer patients required residential care placements at discharge.

This innovative intervention allowed us to challenge the fundamental basis of "I do it for you" to "I will do it with you", allowing the patient to become an integral partner in their health care.

Problem

The population of 65 to 84 year olds in the UK is predicted to increase by 39%, and that of the over 85s by 106%, by 2032.[1]

Care services in hospital and in the home are at capacity, and are often delivering care at speed. This hectic pace can lead to a passive delivery of care across all staff groups in a manner which may be debilitating our older patients, building dependency and reducing their independence. At best this will maintain care needs and add additional strain onto already overstretched community care services.

Our patient, carer, and staff feedback clearly tells us that service users and carers are frequently disempowered by acute care provision, environments, and attitudes. This debilitates individuals mentally and physically and reduces their independent functioning, which for elderly or vulnerable service users may mean prolonged rehabilitation and care, or that they become unfit to return home. The impact of this is very significant for our patients, their families, and for all components of acute, community, and social care capacity.

We aimed to address this issue by developing a way that we could become partners with our patients in their recovery from an acute episode. Our study took place at the Royal Hampshire County Hospital Winchester, part of Hampshire Hospitals NHS Foundation Trust in the UK, which has an older persons 28 bed rehabilitation ward.

Background

The Office of National Statistics for the UK are reporting on the significant increase in the UK of its older population in the coming years.[1,2]

The Health and Social Care Information Centre [3] reported on the acute NHS services that older people accessed in 2012/13, and their findings showed that 77% of over 85 year olds accessed at least one of the inpatient, outpatient, or accident and emergency services in 2012/13, and that 20% of the over 85 years olds accessed all three.

However, failings in the NHS service have been widely reported, especially concerning the care of older people. In the light of the Francis report, there is a real need to review our practices with all patients that use our services, with particular attention to the older patient in hospital. Older people outweigh all other groups as consumers of NHS services, with 63% being over 60 years of age.[4]

As health care providers, we were very aware from our patient and carers feedback that something crucial was missing in our approach to our patients using our acute services. We spend a lot of time training staff in clinical skills, but little time on how to deliver the message, promote partnership, or encourage patients to participate fully in their recovery at all levels (rehabilitation, learning new medicines, self management, and discharge planning).

To address this we sought an intervention that we could use to support our patients and help them to be engaged in their recovery. Previous research had shown that intervention programs can be developed that reduce patient's dependency and increase patient's independence without compromising levels of care and

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compassion.[5,6]

We were engaged with the health coaching approach through work with our local health promotion team. This approach was being widely reported in the literature as a positive way forward to work with patients to enable them to become, active members of the care team.[7 8]. Health coaching has been described as "helping patients gain the knowledge, skills, tools, and confidence to become active participants in their care so that they can reach their self-identified health goals." [9]

Our aim was to utilise the techniques in health coaching and transform them to support our patients in their recovery in the acute domain. Our intervention therefore lifted and shifted the concept for health coaching into a model for recovery coaching. Our theory was that by changing the conversations and language used between clinician/carer and patient, we could move away from the passive delivery of care with our patients as inactive recipients of care. This would enable us to build partnerships in the care relationship by raising awareness for, and increasing patient's participation in, their recovery.

Baseline measurement

Data was collected in two stages - stage 1: before recovery coaching training had taken place (pre-intervention) and stage 2: after all staff had undertaken recovery coaching training (post-intervention). Patients who met our inclusion criteria for the study were invited to consent to in the project. Then the following data was collected for all participants:

- Basic demographics: gender, age, marital status, place of residence, care needs pre-admission and at discharge
- Hospital Anxiety and Depression Scale (HADS)[10]: a measure aimed at detecting states of depression and anxiety
- Barthel Index Daily Functioning Test[11]: a measure of a person's daily functioning such as feeding, bathing, dressing, etc
- Elderly Mobility Scale (EMS) [12]: scale for assessment of mobility taking into consideration, balance, locomotion and key position changes
- The Modified Falls Self-efficacy Scale (MFES)[13]: to record the patients feelings of self efficacy on discharge from the ward
- Date of discharge, date patient fit for discharge, ie when social care section 5 is completed (to off-set delays awaiting discharge arrangements).

The Barthel scores were routinely collected by the nurses on the ward on admission and discharge. The Elderly mobility scale was routinely taken by the physiotherapist team attached to the ward on admission and discharge. For the benefit of this project the ward doctors collected the HADS score on admission, and the demographic and MFES scale was taken by the research practitioner assigned to the project at discharge. Stage 1 (pre-Intervention) base line data is presented in Table 1.

See supplementary file: ds3733.docx - "Baseline data of HADs Barthel EMS, and MFSE - (n=22) at admission and discharge (Before recovery coaching training)"

Design

The multi-disciplinary team developed the concept of "recovery coaching" to support acute inpatient elderly care rehabilitation. We designed a training intervention, supported in practice, to achieve "coaching conversations" between our staff, our patients, and their families in their day to day interactions. The objective was to promote a sense of partnership in the interaction, particularly with our support staff, as they spend the most time with patients undertaking basic activities of daily living (eg washing, toileting, feeding). The further aim was to mature staff's interactions from a highly task orientated approach to a coaching approach.

An external company with experience in coaching supported us in the design of the intervention and undertook training with every member of the ward staff over a one month period. Each staff member attended a two day workshop where they were presented with the recovery coaching concept and shown how to utilise and practice its techniques within their patient contacts on the ward.

Towards the end of the project a select group of staff members undertook "super coach" training in the recovery coaching concepts so that they would be able to sustain the learning on the ward.

Strategy

We formed a key stakeholder working group to develop the intervention, run the project, and data collection and finally to evaluate and report our findings. Using the PDSA model as our template over three months we developed the following:

Month 1: develop a training intervention that was ward and patient group focused.

Working closely with our partners "The Performance Coach", we developed the "recovery coaching" concept highlighting key coaching techniques we could use in our ward setting. We designed the training around five key care areas that that we (as a team experienced in older people's rehabilitation) felt our older patients would need to be able to do independently and/or have a plan of how to manage before discharge. These were:

- I. Be able to get in and out of bed safely
- II. Be able to get in and out of a chair safely
- III. Be able to wash and dress themselves
- IV. Be able to feed themselves
- V. Be able to go to the toilet.

Month 2: strategy to identify measureable outcomes from the

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patient participants.

Working with our academic partners at the psychology department at the University of Winchester, we identified the most suitable measures to assess changes in patient outcomes on the ward. Using a short PDSA cycle, the most suitable measures on the ward were identified as being the Barthel Daily Functioning Index and Elderly Mobility Scale (EMS).

In order to record the patient's mood so that there were no differences between the pre/post intervention stages, the Hospital, Anxiety and Depression scale (HADS) was chosen as a measure and included in the ward doctor's admission assessment. To measure the patients self confidence at discharge, the Modified Falls Self Efficacy (MFES) scale was added.

Finally, to record service improvement data, patients, care packages on admission and discharge were recorded, along with length of stay. All of these measures were taken at both the pre and post intervention stages of the project.

Month 3: strategy for implementation of research study.

The study was a pre/post intervention design to evaluate the impact of the recovery coaching training on patient and staff outcomes. Ethical approval was granted by The West Midlands (Solihull) NRES Committee. The appointment of a research practitioner rather than a project manager was a great asset as their input enabled the process to run relatively smoothly. Staff became increasingly engaged in the project due to their active involvement on the ward that promoted the buy-in and the enthusiasm of the team.

An inclusion/exclusion criterion was created and undertaken by the ward consultant and medical team. Inclusion was on the basis of medical fitness and capacity to participate. Patients who met our inclusion criteria for the study were invited to consent to be part of the project.

Training sessions were planned to take place halfway through the project timeline so that two distinct data collection stages were created, each lasting three months in length. Training was scheduled over a one month period and back-fill payments were arranged where necessary.

A group of staff were interviewed to allow evaluation of the training and discuss how it felt to use the recovery coaching approach. All analyses were performed by Winchester University to allow for robust and academic rigour in the analysis of the intervention that would be difficult to quantify otherwise.

Results

This study was undertaken on a 28 bed acute elderly care rehabilitation ward at an acute hospital in the South of England.

In total, sufficient data was gathered from 46 participants; 22 in the pre-intervention stage and 24 in the post-intervention stage.

Although these relatively small numbers meant that no statistically significant changes could be found, there was some evidence of change in the post recovery coaching group in their Barthel (ADL) scores and their self efficacy scores (see table 2).

The mean scores indicate that there was a slightly higher increase in the patients independence in terms of their Barthel (ADL) scores in the post intervention group, and that they reported higher feelings of self efficacy on discharge. Changes to place of residence and care needs between admission and discharge were also examined by group (see table 3).

The findings suggest that the intervention is supporting an overall improvement in functional ability and independence on discharge. This could have a significant impact for an aging population. In order to afford care costs in the future, the maintenance of independence will be a key element in managing care costs in terms of length of stay, care homes, and care packages. Maintaining independence has the capacity to prevent delays to discharge and allowing people to return on discharge to their own homes.

The staff reported that coaching conversations with patients/relatives felt more purposeful. They said that they felt more able to have the multifaceted conversations in a constructive way, and had gained value tools to frame these conversations.

"This approach feels very caring and dignified, we are working with individual concerns, that gives patients time and support to develop a plan."

"Earlier conversations with families and involving them more in talking things through, has been a game changer."

"We used to present patients with the solutions now we work together to help them to find their own solutions, this way they own them."

See supplementary file: ds3796.docx - "Results Tables 2 & 3 and Staff Comments Figure 1"

Lessons and limitations

Ethics:

Our academic partners had to seek ethical approval from their university for their part in the study and a pre-requisite was that the NHS had given ethical approval, and ethical approval was granted on its first attempt. However, the trust research department advised that a substantial amendment had to be raised due to changes in the wording in the patient information sheets and data transport to our academic partners. It was not until this was received in late June that data collection could start.

Staff issues:

- Recruitment of a research practitioner delayed the project start by six weeks

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- Ward sister leaving and a new one being appointed
- Staffing shortfalls across all staff groups

The delays encountered by the ethics re-submission and the appointment of the research practitioner, along with the staffing shortfalls, were overcome by changes made to the dates of the recovery coaching training which was adeptly supported by our training consultants 'The Performance Coach'. Our research practitioner worked closely with the ward sister in her transition to the ward and the projects running on the ward. We had anticipated that issues would arise within the running of the project and built in contingency plans to allow us the time to deal with them as they arose.

Data collection:

Undertaking research on an acute elderly care ward and trying to collect information for the study was sometimes difficult due to the medical fitness of the patients and/or their capacity to be able to consent to take part. Diarrhoea and vomiting outbreaks occurred twice during data collection which temporarily halted the project. The research practitioner and ward staff managed the situation as it arose by staying in daily contact.

The self efficacy measure (MFES) had limited reliability in assessing the self-efficacy in this type of cohort of patients as many participants felt that some of the questions did not reflect their normal situations. This was accounted for in the data analysis. In future these questions could be changed to better reflect the patient situation for this part of the investigation.

Things that went well

The recovery coaching training sessions proved invaluable; not only in teaching skills to promote a coaching style on the ward, but also as an effective team-building exercise. The sessions were run with a mixture of staff members in each group. During these sessions each staff member gained a much clearer insight to how each staff group worked daily in their care roles and this insight transferred back out onto the ward after the training and still continues within the ward team. The support of the Health Foundation, who had funded the project through their Shine program, was invaluable.

Our assessment of the effect of the project on the quality of the service and the experience of patients and staff:

Interesting preliminary data, though on a small scale, indicates a trend towards changes in quality. In particular, the Barthel and self-efficacy scores reveal that the post training participants in this study scored higher on these scales at discharge compared to those participants' scores prior to the recovery coaching training. Service improvement data also indicates changes in the following: length of stay decreased, smaller care packages, and less residential care placements.

All of these indicate trends towards lowering costs and increasing independence. With an aging population, interventions such as this will be essential for affordable long and short term care costs in the

NHS and social services.

One of the most tremendous successes of the project has been the impact of the intervention on the ward staff themselves and this has been clearly demonstrated by their reflections on the training, what it means to them and how they provide the care for their patients (see figure 1).

Conclusion

This project sought to gather robust evidence for proof of concept of recovery coaching as opposed to evaluating the financial impact, particularly cash releasing savings. Moreover, calculation of true financial impact is challenging across a system. For example, cost saving in one area may result in increased cost in another.

However, we did anticipate that there may be data and information from the project that suggests cost savings could be achieved, not just within the secondary care context but potentially in the whole health and social care system. In this respect, there were indications that the independence and self-efficacy gains derived by patients from recovery coaching could possibly reduce the level of input post-discharge and that it could prevent discharges to residential care.

This project has demonstrated that recovery coaching can offer positive benefits for both patients and staff. The results are adequately compelling for us now to spread this intervention more widely within our organisation. Our first area for spread will be older people care as we believe we will see a significant impact in this clinical setting.

The teaching of recovery coaching techniques is now a part of the elderly care ward staff's skill set and will continue to be embedded into this ward's patient care culture. Five key staff have undertaken 'super coach' training in recovery coaching, enabling them to continue supporting the current staff in the use of these techniques in their daily patient care. It also means they are skilled now in the ability to teach new staff members as they come onto the ward. These super coaches are actively working on the ward by identifying patients for whom recovery coaching techniques will be beneficial and discussing at weekly team meetings how this is to be achieved.

This project has now been awarded a Shine award from Health Education Wessex in the category 'Wonderful Workforce Solutions' and is a finalist in The Nursing Times Awards 2014

'Care of Older People' category.

We are currently actively seeking funding to extend and spread our work throughout our trust and into social services and permit formal evaluation as we are building the evidence base.

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Declaration of interests

Nothing to declare.

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