

# Rehabilitation RESEARCH REVIEW™

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Issue 66 – 2024

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### Abbreviation used in this issue

**CBT** = cognitive behavioural therapy  
**LBP** = low back pain  
**TBI** = traumatic brain injury

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## Welcome to issue 66 of Rehabilitation Research Review.

We begin this issue with a super interesting study investigating the acceptability, satisfaction, and effectiveness of an interdisciplinary micro-choice-based concentrated group rehabilitation for patients with chronic low back pain, long COVID, or type 2 diabetes. Following on, we can learn a lot from the systematic approach taken by a group of researchers developing a behaviour change intervention to increase the delivery of upper limb constraint-induced movement therapy programmes to people with stroke and traumatic brain injury. We wind up this issue with an interesting study exploring what people recovering from fractures perceive to impact physical activity both in hospital and at home in the 2 weeks following discharge.

I hope that you find the information in this issue useful in your practice and I welcome your comments and feedback.

Kind regards,

**Professor Nicola Kayes**

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## First trans-diagnostic experiences with a novel micro-choice based concentrated group rehabilitation for patients with low back pain, long COVID, and type 2 diabetes: A pilot study

**Authors:** Kvale G et al.

**Summary:** The acceptability, satisfaction, and effectiveness of an interdisciplinary micro-choice-based concentrated group rehabilitation for patients (mean age 48 years, 57% women) with chronic low back pain (>4 months sick-leave; n = 104), long COVID (n = 76), or type 2 diabetes (n = 61), were investigated in this pilot clinical trial. Three phases were implemented: (1) preparing for change; (2) the concentrated intervention for 3-4 days; and (3) integrating change into everyday life. In an aim to break patterns where symptoms or habits contributed to decreased levels of functioning or increased health problems, patients were taught and practiced monitoring and targeting seemingly insignificant everyday microchoices. Group size was ≤10 patients and the patients in each group had similar illnesses. Patients reported high satisfaction with treatment, with a 28.9 (3.2) mean Client Satisfaction Questionnaire (CSQ-8) score at 3-month follow-up. Furthermore, Work and Social Adjustment Scale (WSAS) improved significantly from baseline to 3-month follow-up across diagnoses (20.59 to 15.76), as did Brief Illness Perception Questionnaire (BIPQ) and self-rated health status (EQ-5D-5L) (22.30 to 14.88 and 0.715 to 0.779, respectively, all p < 0.001).

**Comment:** This is super interesting work. Much of our health system, delivery and interventions are diagnostically centred. This is perhaps an artefact of the ever-dominant biomedical paradigm. This of course has its place in acute medical management. However, when we look beyond that to living life in the context of a chronic condition (often a critical component of rehabilitation), there are many patterns and commonalities which transcend diagnosis, and which may be a more meaningful target for intervention. In that sense, the idea of a trans-diagnostic intervention is compelling. The thing I find most appealing is that a trans-diagnostic intervention enables a shift away from symptoms and other features specific to a particular diagnosis, to other aspects which may be critical for managing well with a condition (versus managing a condition well – see [Morgan HM et al., Health Expect. 2017](#) for more on this). The authors point out several key features which they argue sets their intervention apart from more conventional rehabilitation interventions. I found two things particularly interesting. First, a focus on what they refer to as 'microchoices'. In their earlier protocol paper ([Kvale G et al., JMIR Res Protoc. 2021](#)) they explain this further, noting: "Microchoices will be used as a term that refers to the moments when you discover specifically how and where in your everyday life the symptoms are making choices on behalf of you, and where you have an option to choose differently. Participants will be encouraged to do things they have avoided in fear of symptom worsening. It will be emphasised that change is measured in behaviour (what you do) and not in the reduction of symptoms." Second, they embed a specific focus on preparing for change as part of the intervention. That is, they make explicit what the focus of the intervention is and the importance of deciding to initiate change. People were actively encouraged to postpone treatment if they were not ready to engage. I am going to do more thinking and reading around these things. I hope this paper and the approach described sparks some things for you too.

**Reference:** *BMC Med.* 2024;22(1):12

[Abstract](#)

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## Development of a behaviour change intervention to increase the delivery of upper limb constraint-induced movement therapy programs to people with stroke and traumatic brain injury

**Authors:** Christie LJ et al.

**Summary:** As part of the Australian Constraint Therapy Implementation study of the Arm (ACTiveARM), these authors developed a behaviour change intervention targeted at therapists, that aimed to increase the delivery of upper limb constraint-induced movement therapy (CIMT) programmes to people with stroke and traumatic brain injury. They used a theoretically-informed approach for designing behaviour change interventions including identification of which behaviours needed to change (Step 1), barriers and enablers that needed to be addressed (Step 2), and intervention components to target those barriers and enablers (Step 3). A total of 52 physiotherapists, occupational therapists, and allied health assistants took part in one of seven focus groups or individual interviews (n = 6). There were 20 key barriers and 10 enablers identified across 11 domains of the Theoretical Domains Framework that were perceived to influence CIMT implementation. These domains informed the development of the following behaviour change interventions; training workshops, nominated team champions, community of practice meetings, three-monthly file audit feedback cycles, poster reminders, and drop-in support during CIMT.

**Comment:** I think we can learn a lot from the systematic approach taken by this group to develop an implementation package. One could take the principles of this approach and apply them in other settings and contexts to support implementation of new initiatives and ways of working. In their first step they drew on a range of data sources to explore the evidence-practice gap, with a focus on unpacking whose behaviour needs to change, and what needs to be done differently. They identified three specific evidence-practice gaps including: (1) that less than 3% of eligible candidates for CIMT were being offered or considered for CIMT; (2) less than 2% of eligible candidates received CIMT; and (3) when CIMT was being conducted, it was not being delivered with high fidelity to key treatment principles. Just doing this step alone may be critical to successful implementation as it offers insights into the source of the problem, rather than making assumptions. Their second step then sought to explore in depth the barriers and enablers to CIMT implementation, capturing both therapist and patient perspectives and informed by behaviour change theory. Being explicitly informed by behaviour change theory was key to their third step as that enabled them to systematically map the barriers and enablers to evidence-based intervention components and functions. This ensures the strategies embedded in the implementation package are tailored to address the issues and concerns identified. These steps provide a framework that could be transferable to the development of implementation packages more generally. For those of you who are specifically interested in implementing CIMT, the paper is worth a read as they provide detailed findings which could be formative to your ongoing work.

**Reference:** *Disabil Rehabil.* 2023;Dec 22 [Epub ahead of print]  
[Abstract](#)

### Independent commentary by Professor Nicola Kayes



Professor Nicola Kayes is Associate Dean Research in the Faculty of Health and Environmental Sciences and Co-Director of the Centre for Person Centred Research at Auckland University of Technology. Nicola has a background in health psychology and as such her research predominantly explores the intersection between health psychology and rehabilitation. She is interested in exploring the role of the rehabilitation practitioner and their way of working as an influencing factor in rehabilitation and whether shifting practice and the way we work with people can optimise rehabilitation outcomes. Nicola actively contributes to postgraduate teaching in rehabilitation in the School of Clinical Sciences at Auckland University of Technology.



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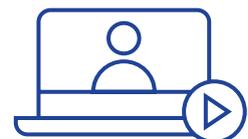
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## Understanding facilitators and challenges to care transition in cardiac rehabilitation: Perspectives and assumptions of healthcare professionals

**Authors:** Ravn MB et al.

**Summary:** It is well recognised that the transition from hospital to community healthcare cardiac rehabilitation services may be challenging for patients with cardiovascular disease. These authors explored assumptions and perspectives among healthcare professionals on how facilitators and challenges influence the transition from hospital to community healthcare cardiac rehabilitation services for these patients. The healthcare professionals relayed their observations and attended focus group interviews, with findings analysed using Interpretive Description methodology. It was revealed that facilitators and challenges could occur in the collaboration with the patient and between healthcare professionals themselves. Furthermore, facilitators and challenges arose due to the new reality for the patient when diagnosed with cardiovascular disease.

**Comment:** I am not sure what the data says in New Zealand regarding current uptake of cardiac rehabilitation. However, low uptake has been a long-debated issue in the literature. The authors note that in Denmark, where this study is set, rates range from 24% to 39%. The transition between hospital to community healthcare may be a critical factor in uptake of cardiac rehabilitation in the community and so the findings of this research may have important implications. There are a few findings that I found particularly interesting. First, the knowledge that was valued and shared between teams differed from inpatient to community, with inpatient professionals valuing more biomedically oriented knowledge, and community professionals valuing psychosocial knowledge – how might this mismatch impact meaningful knowledge exchange across these teams to the detriment of patient engagement? Second, the important role of trust in the relationship between patient and professional was acknowledged as a key factor – how might we support trust to be developed, retained, and maintained during care transitions? My colleague and I have discussed ‘currency of trust’ in past work which may be relevant here (see [Terry G and Kayes N. Disabil Rehabil. 2020](#)). Third, there was a sense that some people don’t self-identify as being ill post discharge from hospital and that uptake and engagement in cardiac rehabilitation (perceived as something for people who were ill) does not resonate for them. What does this mean for how we socialise and communicate the role of cardiac rehabilitation in the community? So, a few insights which I think prompt some important questions that can inform our approach going forward.

**Reference:** *Glob Qual Nurs Res. 2023;Dec 12 [Epub ahead of print]*

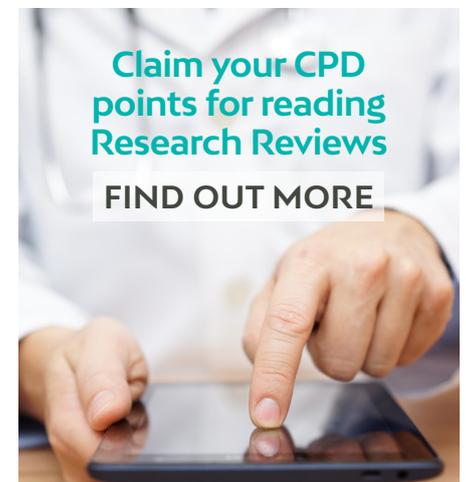
[Abstract](#)

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## A brain computer interface neuromodulatory device for stroke rehabilitation: Iterative user-centered design approach

**Authors:** Alder G et al.

**Summary:** A new complex neuromodulatory wearable technology, exciteBCI, that consists of a brain computer interface, a muscle electrical stimulator, and a mobile app, and augments locomotor rehabilitation for people with stroke, is in the prototype stage. These authors report on the evaluation phase of an iterative user-centered design approach supported by a qualitative descriptive methodology that aims to: (1) explore users' perspectives and experiences of exciteBCI and how well it fits with rehabilitation; and (2) facilitate modifications to exciteBCI design features. The iterative usability evaluation of exciteBCI was undertaken in two phases. Phase 1 involved three sprint cycles consisting of single usability sessions with four stroke patients and four physiotherapists, and at the end of each sprint cycle, device requirements were gathered and the device was modified in preparation for the next cycle. Participants used a "think-aloud" approach during their interactions with exciteBCI, followed by a semi-structured interview. Phase 2, - focused on a "near-live" approach, in which two people with stroke and one physiotherapist participated in a 3-week programme of rehabilitation augmented by exciteBCI, followed by a semi-structured interview. Participants perceived and experienced exciteBCI positively and provided guidance for iterative changes, with the following five themes identified: (1) "This is rehab" showed that participants viewed exciteBCI as fitting well with rehabilitation practice; (2) "Getting the most out of rehab" emphasised that exciteBCI was perceived as a means to enhance rehabilitation through increased challenge and engagement; (3) "It is a tool not a therapist," revealed views that the technology could either enhance or disrupt the therapeutic relationship; (4) "Weighing up the benefits versus the burden"; and (5) "Don't make me look different" stressed important design considerations associated with device set-up, use, and social acceptability. The authors concluded that the study offers several important findings that can inform the design and implementation of rehabilitation technologies, including: (1) the design of rehabilitation technology should support the therapeutic relationship between the patient and therapist; (2) social acceptability is a design priority in rehabilitation technology, but its importance varies depending on the use context; and (3) there is value in using design research methods that support understanding usability in the context of sustained use.

**Comment:** This is an excellent paper. It does several things: (a) it offers insights that will be formative to further development of exciteBCI, which was well received and experienced positively by both physiotherapists and people with stroke; (b) it provides an excellent demonstration of the ways in which you can build on conventional user-centred design methods to generate meaningful data to support the development of accessible, engaging, acceptable, and usable rehabilitation technologies; and (c) it offers a range of transferable findings which are useful to consider in the development of rehabilitation technologies more generally. The discussion was thoughtful and raised some interesting points which point to a complex interaction between the technology, social and relational processes, context of use, workflow, experience, affect, effect, temporality and more. I wonder if we are sometimes at risk of considering these things in isolation, as component parts, in a reductionist way – not just in the development and implementation of rehabilitation technologies, but also in the development and implement of rehabilitation interventions more generally. I am going to ponder this further.

**Reference:** *JMIR Rehabil Assist Technol.* 2023;10:e49702

[Abstract](#)

## The Australian Traumatic Brain Injury Initiative: Systematic review of the effect of acute interventions on outcome for people with moderate-severe traumatic brain injury

**Authors:** Keeves J et al.

**Summary:** These authors undertook a systematic review and consultation to identify acute interventions with potential to modify clinical outcomes for people after moderate-severe traumatic brain injury (msTBI), with the goal of including these interventions in a data dictionary for the Australian Traumatic Brain Injury Initiative (AUS-TBI). Included studies were limited to English-language reports of randomised controlled trials (RCTs) involving  $\geq 100$  patients with msTBI evaluating any association between any acute intervention and clinical outcome. A predefined algorithm was used to assign a value to each observed association and consultation with AUS-TBI clinicians and researchers formed the consensus process for interventions to be included in the data dictionary. Of the 124 full-length RCTs screened, data from 35 studies were included. The studies evaluated 26 unique acute interventions across 21 unique clinical outcomes. A total of 12 interventions were identified as potential modifiers to be included in the AUS-TBI national data resource. Interventions included tranexamic acid and phenytoin, which had a positive effect on an outcome, and decompressive craniectomy surgery and hypothermia, which negatively affected outcomes.

**Comment:** In hindsight, this was possibly not a great paper selection for Rehabilitation Research Review given that the focus is on acute medical and surgical interventions. That said, there are two things that I think are of interest here. First, the AUS-TBI. This appears to be a mammoth piece of work seeking to co-design a data resource to predict outcomes for people with msTBI. This is one of several papers published in recent months. I will be keeping an eye on outputs produced through this initiative. Second, it is interesting to consider the downstream effects of acute interventions and the role that rehabilitation may have in either augmenting the positive or mitigating the negative impacts of those interventions as people navigate life after TBI.

**Reference:** *J Neurotrauma.* 2024;Jan 27 [Epub ahead of print]

[Abstract](#)

## Patients' and therapists' perspective of integrating home and family work roles into rehabilitation following distal radius fracture

**Authors:** Philip S et al.

**Summary:** This study involving 18 patients with distal radius fracture and 11 hand therapist/occupational therapist/physiotherapists explored their perceptions of integrating home and family work roles (HFWR) into rehabilitation. Participants completed semi-structured telephone interviews 3 months after distal radius fracture. Patient interviews revealed the following five themes: the experience of rehabilitation; predetermined expectations of rehabilitation; incorporating HFWR into therapy sessions; varying patient needs for addressing HFWR; and determination to return to valued activities drives behavioral choices. Therapist interviews revealed the following five themes: the challenges in integrating HFWR into rehabilitation; HFWR addressed when brought up by a patient; working context and referral sources influence the rehabilitation plan; rehabilitation is not explicitly tailored according to gender and sex; and utilising HFWR as a rehabilitation strategy is perceived beneficial. Both therapists and patients agreed that adapting HFWR is beneficial, but was not a major focus during therapy. Patient budget constraints, an unfavourable environment, and limited time were identified as challenges to integrating family roles. Patients reported rehabilitation expectations primarily focused on mobility and strengthening exercises.

**Comment:** I have had the privilege of being involved in work led by Julie Collis. Julie is an occupational therapist, and her doctoral work explored the role of daily activity and occupation in recovery following distal radius fracture. She has published widely in this space (see [Collis J et al., Hand Therapy 2020](#); [Collis JM et al., Disabil Rehabil. 2022](#); [Collis JM et al., J Hand Ther. 2023](#)). So, I read this paper with interest, but I will admit to being a little deflated by the findings. Even though therapists identified the benefits of using HFWR as a rehabilitation strategy, they acknowledged that they are only addressed when a patient initiates it or when they perceive the situation warrants it. I can't help but wonder how many assumptions we risk making in our reasoning processes when considering under what circumstances a focus on HFWR is warranted. Further, patients did not expect that HFWR would be part of rehabilitation and instead expected rehabilitation to be focused on exercise interventions. My worry when we hear things like this is that it encourages us to sustain our usual practices in the name of meeting patient expectations. Whereas, instead, I think we should be asking questions like: How has it come to be that patients have such narrow expectations of what rehabilitation can offer them? How have we inadvertently socialised patients to think that rehabilitation is only about what happens in the clinic? What are the risks in this? How could it be different? What might we do differently?

**Reference:** *Disabil Rehabil.* 2024;Jan 29 [Epub ahead of print]

[Abstract](#)

## Empowered Relief, cognitive behavioral therapy, and health education for people with chronic pain: A comparison of outcomes at 6-month follow-up for a randomized controlled trial

**Authors:** Darnall BD et al.

**Summary:** This was a 6-month follow-up of a three-arm randomised trial involving 263 adults with chronic low back pain, that compared a group-based single-session pain relief skills intervention (Empowered Relief; ER), an eight-session cognitive behavioral therapy (CBT) for chronic back pain, and a single-session health and back pain education class (HE). At 3 months' follow-up, non-inferiority of ER vs CBT on an array of outcomes was observed. At 6 months, ER remained non-inferior to CBT on most outcomes, whereas both ER and CBT remained superior to HE on most outcomes. Effects of ER at 6 months post-treatment kept pace with effects reported by those who underwent eight-session CBT. Furthermore, outcome improvements within ER showed no significant decrease from 3 months to 6 months, and ER showed additional 3- to 6-month improvements on pain catastrophising, pain bothersomeness, and anxiety.

**Comment:** This research is motivated by the fact that while CBT interventions have been associated with improvements in pain-related outcomes for people with chronic pain, barriers to access have limited scalability of CBT in practice. The authors argue that a brief, low cost, low burden, psychosocial intervention may address barriers to access particularly for underserved populations and under-resourced settings. ER is a one-off, two-hour session including pain neuroscience education, mindfulness principles, and pain and stress self-regulatory skills. Participants also received a binaural relaxation audio app and completed a personalised plan for empowered belief within the session. The aim of this noninferiority trial was not to simply test the efficacy of ER, or to explore if it was more effective than CBT. Rather, the focus was on determining if ER was at least as good as CBT (in this case, eight x 2-hour sessions). The findings were positive with ER remaining non-inferior to CBT on most outcomes at 6 months follow-up. Achieving the same results as CBT with a one-off 2-hour brief psychosocial intervention session may have important implications for access, reach and engagement. However, the authors promote caution over simply replacing CBT with ER based on these findings. They make a strong case for further research to explore for whom and under what circumstances ER is most likely to be an effective alternative, so that clinicians can make informed decisions. They also note that their population were predominantly white, college-educated, with low rates of psychological comorbidity and so call for further research in more diverse populations. I would add that ER was delivered by doctoral-level psychologists. To truly optimise access, I would suggest seeing if ER can maintain non-inferiority when delivered by other professions, such as physiotherapists.

**Reference:** *Pain Rep.* 2024;9(1):e1116  
[Abstract](#)

## Physiotherapists' barriers and facilitators to the implementation of a behaviour change-informed exercise intervention to promote the adoption of regular exercise practice in patients at risk of recurrence of low back pain: A qualitative study

**Authors:** Moniz A et al.

**Summary:** Physiotherapists' perceived barriers and facilitators to the implementation of a behaviour change-informed exercise intervention aimed at promoting the adoption of regular exercise by patients at risk of low back pain recurrence were investigated in this study. A semi-structured interview schedule informed by the Behaviour Change Wheel, including the Capability, Opportunity, Motivation-Behaviour (COM-B) model and the Theoretical Domains Framework (TDF), was undertaken via videoconference in two focus groups involving a total of 14 primary healthcare physiotherapists. Two independent researchers undertook a deductive content analysis, using a coding matrix based on the COM-B and TDF, and a third researcher settled any disagreements. Thirteen barriers (four COM-B components and seven TDF domains) and 23 facilitators (five COM-B and 13 TDF) to physiotherapists' implementation of a behaviour change-informed exercise intervention were identified, with the most common barriers being lack of skills and confidence to implement the proposed intervention. However, among those who had already implemented other similar interventions or whose rationale was aligned with the new intervention, more positive determinants were evident, including improvement of quality of care, potential benefits for physiotherapists and the profession, and willingness to change clinical practice. Among those who had not previously implemented these types of interventions, more context-related barriers were mentioned, including schedule incompatibilities, lack of time to implement the intervention, and lack of material and human resources.

**Comment:** It is increasingly recognised that education and exercise prescription are not sufficient on their own to support patient engagement in routine exercise practice. Physiotherapists also need to understand and integrate tailored behavioural strategies into practice. However, we are yet to see routine uptake of such strategies by physiotherapists. This research takes a relatively systematic approach to unpacking the reasons why this might be. There is a lot one can take away from the findings of this research and it is certainly worth a read. I was slightly disappointed as the research focused on the implementation of a specific behaviour change-informed intervention package (24 sessions over 12 weeks). The focus on an intervention package versus more routine integration of behavioural strategies in everyday practice is reflected in the orientation of some findings to environmental context and resources as barriers (e.g., scheduling incompatibilities, lack of human resources, experience of failures to implement other interventions). These are likely red herrings which may be more relevant to the intensity of a 12-week intervention, rather than particular to the integration of tailored behavioural strategies. The research also created an arbitrary division between barriers and facilitators. However, it is clear from the findings that the same thing has the potential to be a barrier or a facilitator depending on a whole range of things including context, values, beliefs, etc. So, I would have valued a more in-depth and nuanced exploration of those factors. Research one of my doctoral students is undertaking (watch this space!) highlights that clinician behaviour and management strategies are informed by a complex web of personal and professional beliefs and expectations, patient factors and presentation, and the psychosocial and relational context in which the encounter between patient and practitioner is taking place. Any work we undertake to support clinicians to uptake new ways of working in practice needs to appreciate and respond to this complexity.

**Reference:** *BMC Prim Care* 2024;25(1):39  
[Abstract](#)

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## “We don’t look too much into the communication disability”: Clinicians’ views and experiences on the effect of communication disability on falls in hospital patients with stroke

**Authors:** Sullivan R et al.

**Summary:** Hospitalised patients with communication disability after stroke may have difficulty attracting the attention of health professionals and communicating basic needs, and therefore may be at increased risk of falls. This study explored the perceptions of eleven hospital-based health professionals on the following: (a) the effect of communication disability on falls in patients with stroke; (b) falls prevention strategies for patients with communication disability following stroke; and (c) the roles of speech pathologists in the assessment, management, and prevention of falls in this population. Four online focus groups were conducted. Thematic analysis revealed that health professionals believed the following: (a) the effects of falls in patients with communication disability are far-reaching; (b) communication disability complicates falls risk assessment and falls management; (c) current falls prevention strategies do not meet the needs of patients with communication disability; and (d) strong relationships have a central role in decreasing falls in this population.

**Comment:** This research shines a light on an important issue – that strategies developed to reduce the risk of falls for hospitalised patients have not been designed with people with communication disability in mind. Too often, we design strategies to assess, manage and support people based on the average, the population mean. The downside of this is that this is likely to have ongoing and cumulative effects for those people sitting in the margins. This is just one example of many in the context of people with communication disability. This research sought the perspectives of health professionals on this topic. Professionals were eligible if they had provided services to people with stroke and associated communication disability who had a fall or near miss during hospital admission. Interestingly, the final sample only included nurses, speech pathologists, and medical doctors. I was surprised not to see physiotherapists and occupational therapists taking part given their role in stroke rehabilitation and falls prevention. I found some of the framing in the findings interesting. For example, communication disability was identified as a contributing factor to a fall. I would challenge us to reframe this. Was the communication disability a contributing factor or was it the communication environment that was the contributing factor i.e., where the communication environment does not enable a person to communicate their needs, where staff are too busy to take time with people with communication disability and so on? There is some great research ongoing in New Zealand at the current time (<https://www.hrc.govt.nz/resources/research-repository/embedding-accessible-communication-post-stroke-care>) seeking to embed accessible communication in post-stroke care based on the premise that services need to be communicatively accessible for people to fully access, participate in, and benefit from stroke services. Watch this space!

**Reference:** *Disability and Rehabilitation* 2024;Mar 3 [Epub ahead of print]

[Abstract](#)

## The influence of hospital and home environments on physical activity and sedentary behaviour: Perceptions of people recovering from fractures

**Authors:** Kirk AG et al.

**Summary:** This study used semi-structured interviews within 2 weeks of hospital discharge to describe and compare perceptions of environmental influences on physical activity in hospital and home settings in 12 patients (median age 60 years) recovering from hip fracture or multi-trauma. Thematic analysis via a framework approach revealed the following three main themes that influenced physical activity behaviours in hospital and home settings: (1) having the opportunity; (2) having a reason; and (3) having support and assistance to be active. The authors concluded that during the period of reduced physical capability following fracture, patients need to be provided with opportunities and motivation to be active.

**Comment:** Hospitalisation-related functional decline is a thing i.e., where people experience functional decline between admission and discharge, attributed to prolonged bed rest and other sedentary behaviours. This research sought to explore what people recovering from fractures perceived to impact physical activity both in hospital and at home in the 2 weeks following discharge. The findings point to a range of opportunities to influence physical activity behaviour in both settings. I find the findings relevant to hospital settings most interesting as it feels like such a missed opportunity. Further, the extent to which we support physical activity during people’s hospital stay is surely likely to have flow on effects for them once they are discharged home. These findings highlight that we can implicitly (and sometimes explicitly) signal to people to stay in bed during their hospital stay. We bring food to their bed, use bed pans, have cluttered clinical spaces – all of which reduce opportunities for incidental activity. We are risk-averse, and communicate this through our behaviours and actions, making people feel like they don’t have the permission to move without staff supervision. Alongside this, the sense of busyness on the ward communicates to patients that staff don’t have time to supervise them either. We don’t socialise people to the ward environment, and we don’t talk about physical activity or provide advice on how people might stay active in hospital. Despite all these implicit messages which sustain inaction while in hospital, we then expect that people and their families will be ready, able, prepared, confident, and motivated to be physically active upon discharge home. I know there is some great work going on in this space, such as the [#EndPjparalysis](#) movement which has been taken up by some hospitals in New Zealand. This is excellent! We need to back movements like this with shifts in our hospital structures, environments, and discourses for more sustained changes to practice.

**Reference:** *Injury* 2024;55(4):111488

[Abstract](#)

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