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Domiciliary therapy during inpatient rehabilitation treatment for patients with an acquired brain injury: a preliminary study

Anne M. Boonstra¹, Wilma Wijbrandi¹ and Jacoba M. Spikman¹,²

The objective was to assess the feasibility of additional domiciliary treatment for patients with an acquired brain injury while they are still inpatients at a rehabilitation centre. This cohort study included 22 patients with an acquired brain injury (mainly stroke) and with moderate to severe neuropsychological deficits. After two observational home visits for goal setting to determine the aim of the treatment, domiciliary treatment was given once a week in addition to the therapy at the rehabilitation centre. The number of home visits depended on the time interval between admission and time of inclusion in the study. The main outcome measures were (1) a semi-structured interview with patients and partners or children, (2) a questionnaire filled in by the attending therapist(s) before and after each therapeutic home visit and (3) the functional level of the patient. All but one of the patients and all partners and therapists were satisfied with the domiciliary treatment. Most of the main goals were attained during the treatment. The main goals during the domiciliary treatment were in the domains of domestic activities and leisure. A 90–120 min duration of the treatment sessions seems most feasible. It was concluded that domiciliary treatment for inpatients is feasible and seems useful for patients with moderate to severe cognitive impairments.


El objetivo fue evaluar si es viable o no realizar tratamiento domiciliario adicional a pacientes con daño cerebral adquirido que aún se encuentran hospitalizados en un centro de rehabilitación. Este estudio de cohorte incluyó a 22 pacientes con daño cerebral adquirido (principalmente por derrame cerebral) y con déficit neuropsicológico moderado o severo. Después de dos sesiones experimentales destinadas a establecer los objetivos del tratamiento, se llevó a cabo el tratamiento domiciliario una vez a la semana, como complemento de la terapia recibida en el centro de rehabilitación. El número de sesiones de tratamiento domiciliario dependió del intervalo de tiempo transcurrido entre el ingreso y el momento de inclusión en el estudio. Las principales medidas de los resultados fueron 1) una entrevista semiestructurada a los pacientes y a sus parejas o a sus hijos, 2) un cuestionario que llenaba el terapeuta (o los terapeutas) encargado(s) de realizar el tratamiento domiciliario, antes y después de cada sesión, y 3) el grado de funcionalidad del paciente. Todos los pacientes, excepto uno, y todas las parejas de los mismos y los terapeutas quedaron satisfechos con el tratamiento domiciliario. Durante las sesiones de tratamiento se cumplieron la mayoría de los objetivos. Los principales objetivos del tratamiento domiciliario estuvieron relacionados con las esferas de las actividades domésticas y las recreativas. Parecen ser que las sesiones de tratamiento de entre 90 y 120 minutos de duración son las más factibles. Se llegó a la conclusión de que el tratamiento domiciliario a pacientes ingresados es viable y que parece ser de utilidad para pacientes con alteraciones cognitivas moderada o severa.

L’objectif était d’évaluer la faisabilité d’un traitement complémentaire à domicile pour les patients souffrant de lésions cérébrales acquises alors qu’ils sont encore patients en ambulatoire dans un centre de rééducation. Cette étude portait sur 22 patients souffrant de lésions cérébrales acquises (principalement suite à des accidents vasculaires) et présentant des déficiences neuropsychologiques modérées à sévères. Après deux visites d’observation à domicile en vue de définir les objectifs du traitement, le traitement a été administré à domicile une fois par semaine en complément des séances au centre de rééducation. Le nombre de visites à domicile dépendait du délai entre l’admission au centre et la participation à l’étude. Les principales mesures adoptées étaient (1) un
entretien semi-structuré avec les patients et leurs conjoints ou enfants, (2) un questionnaire rempli par le thérapeute participant avant et après chaque visite à domicile et (3) le niveau fonctionnel du patient. Tous les patients, à l’exception d’un seul, tous les conjoints et tous les thérapeutes se sont déclarés satisfaits du traitement à domicile. La plupart des objectifs fixés ont été atteints pendant le traitement. Les principaux objectifs du traitement à domicile portaient sur les activités domestiques et de loisir. Des séances de durée 90–120 min semblent les mieux adaptées. Il a été conclu que le traitement à domicile pour les patients en ambulatoire constituait une option réalisable et qui paraît utile pour les patients souffrant de difficultés cognitives modérées à sévères. International Journal of Rehabilitation Research 28:211–218 © 2005 Lippincott Williams & Wilkins.

Introduction

Acquired brain injury (ABI), such as stroke and traumatic brain injury, may have severe and long-lasting physical, cognitive, emotional and social consequences for patients and their families. Some of the patients who survive an ABI receive multidisciplinary rehabilitation treatment to restore their functioning and activities of daily living (ADL). Depending on the level of physical and cognitive functioning, admission to a rehabilitation centre is necessary for a proportion of these patients to get adequate treatment and care.

Many patients with ABI have neuropsychological deficits (Hochstenbach et al., 1998; Spikman et al., 2000). Some of these patients, especially those with executive and memory deficits (Berg et al., 2000; Fasotti and Spikman, 2002), can be expected to have specific difficulties transferring the skills they have learned from one setting to another. If all training occurs in a clinical setting, the home situation will remain unfamiliar to the patient and the new skills acquired at the rehabilitation centre may be difficult to transfer to the home environment. Therefore, some clinicians have postulated that therapeutic interventions should be provided in the home situation. Home-based rehabilitation has been proposed to address these problems and recent trials indicate that interventions involving occupational therapy or physiotherapy at home or an early discharge home are feasible and possibly effective (Forster and Young, 1992; Rodgers et al., 1997; Gilberston et al., 2000; Indredavik et al., 2000). However, other authors (Gladman et al., 1993; Rudd et al., 1997; Widén Holmqvist et al., 1998; Anderson et al., 2000; Mayo et al., 2000; Özdemir et al., 2001; Askim et al., 2004; Lincoln et al., 2004) found no overall differences between domiciliary treatment and hospital-based services, nor benefits from early discharge. One possible cause of this difference may be that only certain subgroups benefit from domiciliary treatment (Gladman et al., 1993; Indredavik et al., 2000; Disler and Wade, 2003).

For many patients with ABI, the sequelae of the ABI are such that discharge to the home situation is not feasible or safe and inpatient rehabilitation with 24 h care is required. We assumed that it is particularly the subgroup of patients with moderate to severe neuropsychological deficits who are still in an inpatient setting who may benefit from domiciliary therapy. It is particularly in this subgroup that difficulty in transferring learned abilities from the inpatient setting to home may hamper further rehabilitation and safe functioning at home.

Before conducting a clinical trial to test this assumption, we first wanted to investigate whether additional domiciliary therapy for patients still resident in a clinical setting is feasible and why domiciliary therapy may or may not be useful. According to Ballinger et al. (1999), the content of a therapy needs to be understood before outcomes can be truly interpreted and properly measured.

The present study aimed to assess the feasibility of domiciliary treatment, additional to conventional therapy, for patients with an ABI who are still inpatients of a rehabilitation centre; to examine the goal-setting process during the therapy; to assess the level of satisfaction with the programme among the patients; and to identify factors affecting the usefulness of the programme, if usefulness should be demonstrated. A cohort study design was chosen for this purpose.

Methods

Setting

The ‘Revalidatie Friesland’ Rehabilitation Centre is a regional centre catering for a mixed urban and rural area of approximately 3400 km² with approximately 640 000 inhabitants.

Patients

Patients admitted to the ‘Revalidatie Friesland’ Rehabilitation Centre between March 2001 and September 2002 were considered for inclusion. Of these, adults with ABI were selected for further evaluation. Inclusion criteria were: 1) age over 18 years; 2) ABI as a result of stroke or traumatic brain injury; 3) hospital admission for rehabilitation; 4) domiciliary treatment advisable. Exclusion criteria were: severe neuropsychological deficits; severe physical disabilities; severe cognitive decline; severe medical and/or psychiatric disorders; severe neurological disorders; additional severe cognitive disorders; safety or care issues; patients unable to give informed consent; patients for whom the costs of domiciliary treatment exceed their health insurance benefit. To ensure homogeneity of the sample, patients who did not meet all the criteria were excluded from the present study.

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2003 because of an ABI with moderate to severe neuropsychological deficits were included in the study if they were able to make the transfer to a common car. Excluded were patients younger than 18 years, those with ABI due to brain tumour or a progressive illness such as multiple sclerosis and those with severe co-morbidity greatly influencing function and activities. Twenty-two patients were included. Informed consent was obtained from all patients. None of the patients who were asked to participate refused. The local medical ethics committee evaluated the study protocol and approved the study.

Domiciliary therapy
After admission to the rehabilitation centre, patients entered the regular therapy scheme with physiotherapy, occupational therapy, consultations with a social worker and, if indicated, speech therapy. In addition, they received regular nursing care. Physical therapy was given according to the Bobath principles. After patients had been included in the study, which could be at any time during their inpatient rehabilitation, they continued inpatient treatment. In addition to the conventional therapy, a therapist took each patient with them in the car for a home visit once a week. After a home visit, the patient returned to the rehabilitation centre with the therapist. The home visit programme started with two observational visits to inspect the situation and observe the patient’s performance at home and to set goals. The observational home visits were done by the occupational therapists, mostly together with the cognitive therapist. After these first observational visits, the home-based therapy started. Further home visits were made with various therapists of the multidisciplinary team, depending on the goal(s) to be attained. The patient’s partner or one of their children was encouraged to be present during the home visits.

The frequency of the therapeutic home visits was once a week, sometimes less if circumstances prevented a visit. The standard duration of each home visit was set at 2 h, but this could be shortened or lengthened by the therapist if needed, depending on the patient’s mental or physical fatigability or the time required to practise a particular activity. Patients were discharged home within 2 weeks after their last home visit.

Assessments
Patient characteristics
Demographic characteristics of the patients (age, sex and marital status) were recorded. Data on the etiopathogenesis of the ABI, the onset date and the time interval until rehabilitation were inferred from medical records. These characteristics are listed in Table 1.

During the initial period, a neuropsychologist performed a neuropsychological examination. Detailed information on the neuropsychological tests can be obtained from the first author (AMB) on request. Patients were included if the neuropsychologist’s interpretation of the tests led to a conclusion of moderate to severe cognitive disorder. One patient was not tested at all due to severe aphasia and visual impairment. Observations of this patient by the occupational therapist and psychologist showed neuropsychological impairments, but we were unable to quantify these.

Table 1 Characteristics of the 22 patients included

<table>
<thead>
<tr>
<th></th>
<th>Median</th>
<th>Inter-quartile range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>58</td>
<td>48–70</td>
</tr>
<tr>
<td>Time from onset to admission (days)</td>
<td>30</td>
<td>18–55</td>
</tr>
<tr>
<td>Time between admission and discharge (days)</td>
<td>151</td>
<td>100–192</td>
</tr>
<tr>
<td>Sex (men/women)</td>
<td>8/14</td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke (infection)</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Stroke (haemorrhage)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Postanoxic encephalopathy</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injury</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Partner (yes/no)</td>
<td>19/3</td>
<td></td>
</tr>
</tbody>
</table>

*Time from the onset of the acquired brain injury to admission to the rehabilitation centre.

Functional assessments
The patients’ functional status was assessed after inclusion in the study, that is, just before the start of the domiciliary therapy, as well as just after its completion, using the Barthel Index (Mahoney and Barthel, 1965), the Hoenbroeck Disability Scale (HDS) (Torenbeck et al., 1998) and the first part of the Arnadottir OT-ADL Neurobehavioral Evaluation (A-one): (Gardarsdottir and Kaplan, 2002). The Barthel Index is a functional evaluation by means of a questionnaire filled in by a patient’s physician or nurse, with ratings from 0 to 20. The HDS is a questionnaire to assess the physical, mental and social functioning and communication domains, scored by patients’ therapists and nurses. The A-one (part one) assesses the following domains: dressing, grooming and hygiene, feeding, transfers and mobility and communication. It is an observational instrument, administered by an occupational therapist. The HDS and the A-one both use scores from 0 to 100. In all three assessments, higher scores indicate better functioning.

Other assessments
Patients and their partners were interviewed before and after the domiciliary therapy (including observational home visits). If patients had no partner, one of their children was interviewed. Before the domiciliary therapy, patients were asked what main goal they wanted to attain. If a patient was severely aphasic, the goal set by their
The occupational therapists who administered the observational home visits were asked to record the main goal set for the domiciliary therapy. They categorized the goals according to the RAP domains mentioned above.

The therapists involved in the domiciliary therapy were asked which goals were set for each particular home visit and what the main goal was. They also categorized the goals according to the RAP domains. After each home visit, the therapists were asked to provide information about travelling time, duration of the home visit, whether this duration had been suitable, too short or too long, whether the goals for the visit had been attained (the categories were no, to some extent, for the greater part or completely) and whether they were satisfied with the domiciliary therapy (by giving a mark between 0 = not satisfied at all and 10 = very much satisfied).

The degree to which a goal had been attained during the domiciliary therapy was analysed for the main goals only and was done as follows: the goal was tracked in the questionnaires from consecutive home visits and the final judgement was used in the analysis. The number of main goals was smaller than the number of home visits, because a goal was frequently not attained in one home visit.

Statistical analysis

Data were entered and analysed by means of the descriptive and non-parametric statistics in the SPSS statistical analysis program, version 11 for Windows. Because the data were not normally distributed, we used the median (50th percentile), the range and quartiles (25th–75th percentiles: inter-quartile range (IQR)). The difference in functioning before and after the domiciliary therapy was tested using the non-parametric Wilcoxon's matched-pair rank test. The chosen significance level was \( \alpha = 0.05 \).

Results

Twenty-one patients, 19 partners and one of the children of each of the three patients without partners were interviewed before the start of the domiciliary therapy. One patient could not be interviewed due to severe aphasia. Data from the interview with one patient and partner at the end of domiciliary treatment were lost. Three partners refused to be interviewed at the end of the domiciliary therapy. All but one of the patients had been discharged from the stroke unit of a general hospital to the rehabilitation centre. One patient, with encephalitis, was initially discharged home after her hospital admission but was admitted to the rehabilitation centre because her functional problems were too severe.

Domiciliary therapy

Start, duration and frequency

The first observational home visit was performed in the seventh week after admission for one patient, in the eighth week for three patients and in the ninth week or later for all other patients. The median time between admission to the rehabilitation centre and the first observational home visit was 62 days (IQR, 32–97 days).

Four patients had only two observational home visits. These patients were found to be functioning well enough...
at home to be discharged home. For the other 18 patients, the domiciliary therapy started after the observational home visits. A total of 108 domiciliary visits were made, with a median of four per patient and a range of 2–22 visits (IQR, 3–7). The other characteristics of the domiciliary therapy are presented in Table 2. Two home visits with one patient were shortened (to 15 min) because of personal circumstances of the partner or because the patient felt ill. Most of the therapeutic home visits (53 of the 108) took approximately 2 h, as planned, but a considerable number (19 of the 108) were shortened to approximately 90 min because of mental or physical fatigue on the part of the patient or because the training of a specific activity did not take more time. The therapists mostly rated the planned duration of the therapy as good (see Fig. 1).

Therapists involved
The disciplines of the therapists performing the therapeutic home visits are listed in Table 3. The most common discipline involved in the domiciliary therapy was that of the occupational therapist (73% of the therapeutic home visits). A speech therapist was sometimes involved, in the case of patients with aphasia, mostly in combination with another therapist.

Goals
The domains of the main goals stated by patients and occupational therapists after the observational home visits are shown in Figure 2. In one case it was decided that the patient could be discharged home after the occupational therapist had already defined a goal. As the domiciliary therapy got underway, main goals changed and so several goals for the individual therapeutic home visits could be set for each patient. Figure 3 shows the domains of the main goal of each home visit, for all 108 therapeutic home visits.

Table 2 Characteristics of the therapeutic home visits of 18 patients

<table>
<thead>
<tr>
<th></th>
<th>Median</th>
<th>Range</th>
<th>Inter-quartile range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number per patient</td>
<td>4</td>
<td>2–22</td>
<td>3–7</td>
</tr>
<tr>
<td>Duration of therapy session (min)</td>
<td>120</td>
<td>15–165</td>
<td>90–120</td>
</tr>
<tr>
<td>Travelling time (min)*</td>
<td>60</td>
<td>20–150</td>
<td>60–90</td>
</tr>
</tbody>
</table>

n (total) = 108.

*Travelling time without getting into and out of the car.

Fig. 1

Number of therapeutic home visits (n (total) = 94, 14 missing pieces of data) with durations shorter than 80 min, 80–105 min and 110–130 min and longer than 130 min, showing the therapists’ opinion about this duration (too long, adequate or too short).

Table 3 Disciplines of the therapists carrying out the therapeutic home visits

<table>
<thead>
<tr>
<th>Attending discipline</th>
<th>Number of home visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational therapist</td>
<td>70</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>8</td>
</tr>
<tr>
<td>Speech therapist</td>
<td>1</td>
</tr>
<tr>
<td>Cognitive therapist</td>
<td>1</td>
</tr>
<tr>
<td>Leisure therapist</td>
<td>15</td>
</tr>
<tr>
<td>Combination (two therapists)*</td>
<td>13</td>
</tr>
</tbody>
</table>

n (total) = 108.

*Combinations were used for six patients: occupational therapist and speech therapist in seven visits; physiotherapist and cognitive therapist in two visits; physiotherapist and speech therapist in two visits; occupational therapist and physiotherapist in two visits.

Fig. 2

Main goals set by patients before the start of domiciliary therapy and by occupational therapists after the observational home visits, categorized by domain (none, indoor mobility, outdoor mobility, self-care, domestic activities, leisure, communication and ‘other’).

Table 4 shows whether the main goals set by the patients before the start of the domiciliary therapy and those set by the therapist before each therapeutic home visit were attained during the domiciliary therapy. The reasons mentioned by the therapists as to why some goals were not attained were that certain goals appeared to be unrealistic because of the patient’s cognitive disorders, or that the patient was discharged home although some specific goals had not yet been attained.

Usefulness and problems
After the home visits, only six of the 108 therapy sessions were not considered useful by the therapists. The causes

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were (1) patient was too tired, (2) no added value of treatment at home over treatment at rehabilitation centre, (3) treatment could not be administered due to family circumstances; (4) patient refused to practise the planned activity, (5) patient became ill and (6) goal of the visit was unclear. The reasons why the therapists considered the therapy to be useful are given in Table 5.

Satisfaction with the therapy among patients and their partners or children
All but one of the patients were satisfied with the domiciliary therapy. The one patient who was not satisfied reported that ‘she had not learned much’. All partners or children considered the domiciliary therapy to be useful. The reasons mentioned by the patients and partners or children for why the domiciliary therapy was useful were not very specific, including expressions like ‘it is pleasant to practise at home’ and ‘home is different from the rehabilitation centre’.

The marks (on a scale from 0 to 10) for the domiciliary therapy given by the patients and their partners or children ranged from 0 to 9 and from 5 to 9, respectively, both with a median of 8 (IQR, both 7–8).

Functional level of the patients
The functional level of the patients increased during the period of domiciliary treatment. The scores on the Barthel Index, HDS and A-one before and after the domiciliary therapy are listed in Table 6. All patients were ultimately discharged home.

Discussion
This study shows that domiciliary treatment for patients with ABI during inpatient rehabilitation is feasible. Several practical problems were encountered, but most of them were surmountable and the majority of the home treatment sessions were useful.

All patients had initially been admitted to a stroke unit of a general hospital after the ABI. All but one were discharged to the rehabilitation centre. One patient was discharged home. She skewed the data of the characteristics as shown in Table 1. Nevertheless, we had no reasons to exclude her because she met the inclusion criteria and her neuropsychological impairment was comparable to that of the other patients.

The therapists in our study mentioned that some patients functioned better at home than at the rehabilitation centre. This is in agreement with the findings of

**Table 5** Factors that are important for indicating domiciliary therapy or that determine the usefulness of the domiciliary therapy

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of patients for whom the factor was mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has difficulties transferring tasks</td>
<td>8</td>
</tr>
<tr>
<td>Patient functions better at home</td>
<td>4</td>
</tr>
<tr>
<td>Specific activities were trained</td>
<td>8</td>
</tr>
<tr>
<td>Improving the patient’s insight</td>
<td>4</td>
</tr>
<tr>
<td>Improving the partner’s or family’s insight</td>
<td>8</td>
</tr>
<tr>
<td>Improving the therapist’s insight</td>
<td>9</td>
</tr>
<tr>
<td>Involving the partner in the treatment</td>
<td>6</td>
</tr>
<tr>
<td>Increasing the patient’s self-confidence</td>
<td>4</td>
</tr>
</tbody>
</table>

**Table 6** Functional status of the patients before and after the domiciliary therapy

<table>
<thead>
<tr>
<th></th>
<th>Before domiciliary therapy (median (inter-quartile range))</th>
<th>After domiciliary therapy (median (inter-quartile range))</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barthel Index</td>
<td>18.5 (14–20)</td>
<td>19 (18–20)</td>
<td>0.005</td>
</tr>
<tr>
<td>A-one</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>65 (30–97)</td>
<td>100 (88–100)</td>
<td>0.002</td>
</tr>
<tr>
<td>Grooming and hygiene</td>
<td>75 (64–100)</td>
<td>100 (100–100)</td>
<td>0.012</td>
</tr>
<tr>
<td>Transfer and mobility</td>
<td>100 (57–100)</td>
<td>100 (100–100)</td>
<td>0.018</td>
</tr>
<tr>
<td>Feeding</td>
<td>94 (72–100)</td>
<td>100 (100–100)</td>
<td>0.063</td>
</tr>
<tr>
<td>Communication</td>
<td>92 (48–100)</td>
<td>100 (94–100)</td>
<td>0.001</td>
</tr>
<tr>
<td>Total score</td>
<td>77 (66–94)</td>
<td>99 (93–100)</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical score</td>
<td>84 (60–93)</td>
<td>91 (75–97)</td>
<td>0.000</td>
</tr>
<tr>
<td>Mental score</td>
<td>64 (55–75)</td>
<td>75 (64–85)</td>
<td>0.000</td>
</tr>
<tr>
<td>Social score</td>
<td>38 (25–49)</td>
<td>48 (44–60)</td>
<td>0.001</td>
</tr>
<tr>
<td>Communication</td>
<td>61 (40–84)</td>
<td>69 (56–83)</td>
<td>0.050</td>
</tr>
<tr>
<td>Total score</td>
<td>62 (62–71)</td>
<td>69 (61–79)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Barthel Index, HDS and A-one before and after the domiciliary therapy are listed in Table 6. All patients were ultimately discharged home.
Park et al. (1994) and Darragh et al. (1998), who showed that patients who have had a stroke and are living at home perform instrumental ADL tasks better in a familiar setting than in an unfamiliar setting.

The therapists perceived the possibility of informing and involving the patients’ partners as an important advantage of the domiciliary treatment. Lincoln et al. (2004) showed that carers of patients treated by the community stroke team were under less strain and more satisfied with aspects such as the emotional support they received. This is in agreement with our finding that it is easier to inform and involve the carers in domiciliary therapy than in the usual care.

Another important aspect mentioned by the therapists was that the domiciliary therapy sessions gave them an opportunity to gain better insight into the patients’ home circumstances. Observing a patient at home gives a better impression of patients’ real disabilities and activities, allowing more realistic goal setting.

In our study, the goal-setting process was used to decide which therapist was to carry out the therapeutic home visits. Because the goals were mainly in the domains of domestic activities and leisure, occupational therapists were involved in most cases. However, physiotherapists were involved especially for goals in the mobility domain and speech therapists for those in the communicative domain. This proved to be useful in teaching patients and partners to communicate in practical situations.

Although the domiciliary therapy in our study was not restricted to any specific discipline, nurses were not involved in the treatment at home. This was probably because only one patient mentioned personal care as the most important goal and this goal could be achieved by practising personal care at the rehabilitation centre. In addition, transferring of personal care activities from the rehabilitation centre to home may be less difficult than more complex activities in the domains of housekeeping and leisure.

Our study showed that the duration of the therapy sessions (approximately 90–120 min) was appropriate. Sometimes the duration was shortened or lengthened because of mental or physical fatigue on the part of the patient or because the duration was adapted to the activity. Most reports of similar studies in the literature do not mention the frequency and duration of the therapy sessions, though one article (Gilbertson et al., 2000) reports a duration of 30–45 min and another (Özdemir et al., 2001) reports one of 2 h. Reporting frequency and duration of therapy is important, because this may explain differences between the findings of various studies. Kwakkel et al. (1997) have shown that the intensity of the therapy is probably related to its effectiveness.

Although home-based therapy has been regarded as a promising development in the care of ABI patients for some years now, a recent meta-analysis by the Cochrane Collaboration (2000) found no evidence that home-based treatment differs from conventional treatment in terms of patient outcomes, caregiver health or resource utilization. It is, however, a challenge to clinicians to find the subgroups of patients who could benefit from home-based therapy and to define the best model for such therapy (Disler and Wade, 2003). Domiciliary therapy for patients in an inpatient setting seems a promising option for the subgroup of patients with moderate to severe cognitive impairment. To our knowledge, no randomized controlled trial has as yet been performed to show the effectiveness of domiciliary therapy for patients in an inpatient setting. The design of the present study also precludes conclusions on effectiveness. Although the patients in our study did show an improvement in functional scores before and after the domiciliary therapy, and this improvement may have been facilitated by the domiciliary therapy, the rehabilitation treatment as a whole and natural recovery will have contributed too. More research in this field is clearly needed.

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References


